DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit survey to the abbreviated survey ending 3/31/16 and first revisit survey ending 5/12/16 was conducted 6/28/16 through 6/30/16 . Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints was investigated during this survey. The census in this 190 certified bed facility was 175 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents # 201 through # 216 and # 218 through # 221) and one closed record (Resident # 217).	{F 000}	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	{F 280}	1. Resident #218 care plan was revised on 6/27/16. Resident #219 care plan was revised on 6/27/16. Resident #205 care plan was revised on 6/28/16.	7/27/2016

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles E Phillips Jr | TITLE: ED | (X6) DATE: 7-14-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to review and revise the comprehensive care plan for three of 21 residents in the survey sample, Residents #218, #219 and #205.

1. The facility staff failed to revise the care plan for Resident #218 after an altercation with Resident #219 on 6/25/16.

2. The facility staff failed to revise the care plan for Resident #219 after an altercation between him and Resident #218 on 6/25/16.

3. The facility staff failed to revise Resident #205's care plan after the 6/22/16 altercation with another resident.

The findings include:

1. Resident #218 was admitted to the facility on 5/18/15 and most recently readmitted on 9/25/15 with diagnoses including, but not limited to: Schizoaffective disorder (1), bipolar disorder (2), and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date (ARD) of 4/13/16, Resident #218 was coded as being severely cognitively impaired for making daily decisions,

2. Residents currently residing in the facility have the potential to be affected. Incident and accident reports have been reviewed there have been no resident to resident incidents since 6/25/16.
3. In-servicing has been provided to the nursing supervisors by the DCS regarding updating plan off care immediately following any incidents to include resident to resident altercations. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that interventions have been implemented at the time of incidence.
4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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having scored five out of 15 on the BIMS (brief interview for mental status). He was coded with all zeros for indicators of mood difficulties, and as having no behaviors during the look back period. He was coded as being independent for walking in his room and in the corridor on the unit, and as requiring the supervision assistance (oversight, encouragement or cueing) of staff for moving to and returning from off-unit locations.

On 6/29/16 at 8:05 a.m., Resident #218 was observed in the dining room eating breakfast. He was alert. He spoke rapidly, and his speech was unintelligible to this surveyor. He spoke to the surveyor, to his table mates and to surrounding staff. He alternated outbursts of speech with eating his breakfast.

On 6/29/16 at 4:05 p.m., Resident #218 was observed sitting in the dining room alone. No other residents were around him.

On 6/30/16 at 8:55 a.m., Resident #218 was observed walking independently into the dining room, speaking to staff, looking around, and taking a seat at a table to which the staff led him. His speech was intelligible, as he spoke about breakfast.

Resident #219 was admitted to the facility on 10/16/15 with diagnoses including, but not limited to: dementia, major depression, and cognitive communication deficit. On the most recent MDS, an annual assessment with assessment reference date 3/28/16, Resident #219 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS. He was coded with all zeros for indicators of mood difficulties, and as having

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no behaviors during the look back period. He was coded as requiring supervision assistance (oversight, encouragement or cueing) of staff for walking in his room and in the corridor on the unit, as well as for moving to and returning from off-unit locations.

A review of the progress notes for Resident #219 revealed the following note written 6/25/16 at 10:00 a.m. by LPN (licensed practical nurse) #9: "Resident in the dining room approached [name of Resident #218 - crossed through with one line] resident and pushed him while [Resident #218] was getting up. [Resident #218] fell. [Resident #219] stated that [Resident #218] was cursing at him. Both residents were separated. Will continue to monitor. All am (morning) meds (medications) given."

A review of the progress notes for Resident #218 revealed the following note (unsigned) written on 6/25/16 at 11:00 a.m.: "Resident alert. Found in the dinning (sic) area buttocks on the floor. He appeared anxious and was talking incessantly. All am meds given prior...no c/o (complaints of) pain. No visible injury noted. Re-directed to his room. Neuro (neurological) checks implemented. Provided comfort and safety measure. Informed resident to use call bell to ask for help. Anti-anxiety pill given and encouraged plenty of fluids. RP (responsible party) not answering, left a message to call back. MD (medical doctor) made aware, no order given, just monitor resident."

Further review of the clinical record for Resident #218 revealed the following note dated 6/25/16 at 7:00 p.m. and signed by a floor nurse who was not available for interview: "Resident came to

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writer and stated that his upper back was hurting. Asked resident what level on a scale of 1-10 and he stated 12. Called MD (medical doctor) and he stated to get X-ray of upper back and start Tylenol extra strength 1 tab po (by mouth) q6h (every six hours) prn (as needed). [Name of mobile X-ray company] notified and will be in facility within the hour. Neuro (neurological) checks in place and within NL (normal limits)."

A review of the X-ray results for the above ordered upper back X-ray for Resident #218 revealed no evidence of the finding of any abnormalities or fractures.

A review of the comprehensive care plan for Resident #218 dated 4/6/16 revealed, in part, the following updates made on 6/25/16: "Neuro checks. X-ray of back. Rehab (rehabilitation services) referral." The review revealed no interventions related to the altercation on 6/25/16 and Resident #218's continued safety from physical altercations with Resident #219 and other residents.

A review of facility document titled "Fall Root Cause Investigation Report" for Resident #218 dated 6/25/16 and signed by LPN #8 the weekend supervisor on duty on 6/25/16 revealed, in part, the following: "Locomotion Status: ambulates (walks) /indept (independent)...Unusual circumstances past 24 hours contributing to fall risks?: increased manic behavior...Identified Behaviors: agitation. Identified patterns of Behaviors (specify): [arrow pointing up] behavior...Resident found sitting on his buttocks in dinning (sic) room. Resolution/intervention for minimizing future occurrences: med (medication) review, neuro

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checks, rehab (rehabilitation) referral."

A review of a document titled "Witness Statement" dated 6/25/16 and signed by LPN #9 revealed, in part, the following: "10:30 a.m. Interviewed [Resident #218] in his room regarding the incident in the dining room. He stated that he was getting up in the chair when another resident from another table approached him and pushed his shoulders resulting him to fall (sic). He stated also that the resident [name of Resident #219] was angry and insecure. He landed buttocks first. He wasn't doing anything to provoke him at that time."

On 6/29/16 at 10:55 a.m., LPN #12 was interviewed regarding anything she saw or heard on the morning of 6/25/16. She stated: "I didn't see anything. I heard [Resident #218] had a fall and the girl did a fall report, or at least she was supposed to." LPN #12 stated she was in charge of caring for Resident #218 on 6/26/16. LPN #12 stated she was not aware of the incident described in the above referenced witness statement. When asked if she was aware of any safety interventions to prevent further altercations between these two residents, she stated: "No."

On 6/29/16 at 11:05 a.m., CNA (certified nursing assistant) #2 was interviewed about the events on the morning of 6/25/16. She stated: "I was not in there (the dining room)." CNA #2 stated she heard that Residents #219 and #218 "got into an altercation and [Resident #219] pushed [Resident #218]." CNA #2 stated she was told to get vital signs on Resident #218. She stated she thought the incident occurred during a meal time. When asked if both residents are able to ambulate independently in the facility, CNA #2 stated: "Yes.

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They were supposed to be separated after that, but I know they can both walk on their own." When asked, since she was assigned to both residents during the current shift, if she was aware of any safety interventions put into place to prevent further altercations, CNA #2 stated: "No. Not right now."

On 6/29/16 at 11:05 a.m., CNA #5 was interviewed about the events of 6/25/16. She stated she did not see or hear anything directly. CN #5 stated ASM (administrative staff member) #3, the director of clinical services, came into the building "sometime" that day (6/25/16).

On 6/29/16 at 11:10 p.m., LPN #11 was asked about the events of 6/25/16. She stated she worked that morning, but did not hear anything "except that [Resident #218] had a fall."

On 6/29/16 at 1:00 p.m., LPN #8, the weekend supervisor working on 6/25/16, was interviewed by telephone. She stated: "The only thing I know is that [Resident #218] had a fall in the dining room Saturday morning." When asked how she became aware of the fall, LPN #8 stated one of the CNAs approached her and told her that Resident #218 was sitting on the floor in the dining room. She stated as she walked down the hallway towards the dining room, she passed Resident #219 exiting the dining room. LPN #8 stated she investigated the fall after breakfast, but there were no witnesses. She stated she completed a facility fall packet. LPN #8 stated later in the evening, Resident #218 complained of pain, and that an X-ray was ordered and obtained, but that the X-ray was negative for any fracture or other pathology. When asked why she was the nurse to complete the fall investigation,

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LPN #8 stated that the nurse for Resident #218 on that shift was not an employee of the facility, but was a temporary nurse from a nurse staffing agency. LPN #8 stated this nurse (LPN #9) was "still on a med (medication) cart when this happened." LPN #8 stated she assessed the resident for all the normal checks after a fall, including range of motion and neurological issues. LPN #8 stated she instructed LPN #9 to go in and check on Resident #218 once she finished her medication administration. LPN #8 stated: "I got [LPN #9]'s witness statement. I was never able to figure out why he fell." When the surveyor read LPN #9's witness statement to her, and asked why this incident, as reported by Resident #218, was not investigated as anything other than an unwitnessed fall, LPN #8 did not respond. When asked if she had read LPN #9's witness statement, LPN #8 stated: "The agency nurse went in and talked to [Resident #218]. He said he was pushed. But he was really manic. No one could substantiate what happened." When asked if anyone interviewed Resident #219 on 6/25/16, LPN #8 stated she tried to talk to him, "but he speaks only Spanish. That is a problem. He speaks only in Spanish. He just kept saying 'I don't love him.'" When asked what the facility staff members have been trained to do in response to the report of a resident to resident incident, LPN #8 stated the staff is supposed to separate the residents, ensure their safety, make sure they are not in the same room and report it to the DCS (director of clinical services). She stated she talked with both ASM #2 and ASM #3 within 15 minutes of the incident. LPN #8 stated: "ASM #2 told me to do an investigation." She continued: "They (Residents #218 and #219) self-separated. [Resident #219] stayed in his room the rest of the day." When asked how she

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knew this, she stated that she and the other staff "checked on him." LPN #8 went on to say that she worked double shifts (16 hour shifts) on both 6/25/16 and 6/26/16. When informed that other CNAs and nurses who worked that day and on 6/26/16 did not know anything about a need for Resident #219 to stay in his room due to safety concerns, LPN #8 did not respond. When asked if she updated the care plan for either resident, LPN #8 stated: "No, I did not. The floor nurse should do the update." LPN #8 stated that the night shift supervisor working from 6/25/16 to 6/26/16 was made aware of the incident. (This nurse was not available for interview during the survey).

On 6/29/16 at 1:50 p.m., LPN #4 was interviewed about the process to be followed after a resident to resident incident. She stated that both residents should be assessed and interviewed. She stated that all documentation should be up to date, and that the physician, social worker, supervisor and family should be notified immediately. She stated that the unit managers are responsible for updating care plans on weekdays, and that the weekend supervisors are responsible for updating care plans on the weekend. LPN #4 stated that the incident described in the 6/25/16 notes for Resident #218 and #219 should have been investigated and the care plan revised for both residents. LPN #4 stated that supervision should have been increased for both residents, especially since they are both independently ambulatory.

On 6/29/16 at 1:55 p.m., ASM #3, the director of clinical services, was interviewed about the events of 6/25/16. ASM #3 stated she was called "when it happened." She stated she came to the

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facility. ASM #3 stated: "You can't interview [Resident #219] because he is Hispanic. There were no injuries. I got witness statements from the staff." When asked from which staff she obtained witness statements, ASM #3 stated: "[LPN #9]." When asked if she obtained any other staff statements, ASM #3 said she did not. She stated: "I did an investigation and wrote it up." At this time, AM #3 provided the surveyor with a typed document dated 6/27/16 and titled "Investigation Synopsis." This document contained neither her name, nor her signature, nor any type of verifiable date stamp. Review of this document revealed, in part, the following: "Re: (regarding) possible resident to resident [Resident #218] and [Resident #219]. Methods of Investigation: Resident interview, Staff interview. Summary of findings:...On June 25, 2016 while in dining room when [Resident #218] came into [Resident #219]'s personal space causing [Resident #219] to become angry and pushing [Resident #218] to the floor. Both residents were separated immediately and assessed for injury. An interview was conducted by staff with [Resident #218] whom (sic) at the time was noted to be rambling with his words and noted to be in a heightened state or mania, however was able to state to staff that "The Hispanic man pushed me" during the interview. Resident was assessed no injuries were noted. [Resident #218] complained of back pain and was medicated with prn Tylenol. A physician's order for an x-ray of the cervical area of the back was obtained and the results were negative. [Resident #219] was interviewed by staff but was unable to give details of the incident but did state, "I told him I don't love him and I pushed him down." Both responsible parties and MD (medical doctor) were notified. In conclusion: After investigating the incident that

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occurred, a psychiatric consult was ordered for both residents because of each resident's altered mental status. Labs (laboratory tests) were also ordered for [Resident #218]. Care plans were also updated to reflect interventions and behaviors." When ASM #3 was asked, again, if the care plans were updated as stated in this document, she stated: "No."

On 6/29/16 at 2:00 p.m., LPN #9 was interviewed by phone. She stated: "The supervisor told me I had to go and interview [Resident #218] after it happened." She stated Resident #218 had been "manic" all morning, as demonstrated by talking quickly and nonsensically. She stated Resident #218 told her that when he was standing up in the dining room, Resident #219 approached him and hit him "vehemently and suddenly." When asked for clarification of the adverbs "vehemently and suddenly," she stated these are her interpretations of what Resident #218 told her. She stated that Resident #218 was adamant that Resident #219's actions were quick and violent. She stated that she also attempted to speak with Resident #219. She stated he told her that Resident #218 was cursing at him, acting as though Resident #218 was going to punch him. She stated she reported the results of both these interviews to the supervisor (LPN #8), and that LPN #8 told her to write down her interview with Resident #218 on a fall report witness statement. She stated she was not asked to write down the results of her interview with Resident #219. When asked if, as an agency nurse, she had received any specific training on this facility's procedures to be followed in the case of a report of a resident to resident altercation. She stated she had not received any such education or in-service. She stated her first reaction would be

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to separate the residents. She stated she had instructed the CNAs working that shift to watch both residents and to "keep an eye on them." When told that none of the CNAs working that day remembered being told to do any sort of special monitoring, she did not respond. When asked if she updated the care plan for either resident, she stated, "No."

On 6/29/16 at 2:15 p.m., LPN #3, who was responsible for both Residents #218 and #219 that day, was interviewed. She stated she was not aware of any interventions put in place to keep these residents apart. She stated, "They both walk the halls all the time."

On 6/29/16 at 3:35 p.m., ASM #2, the regional director of clinical services, was interviewed regarding these events. She stated: "I called the facility on that Saturday like I always do on a weekend. I spoke to [LPN #8] and she said, 'We had an incident.'" She stated LPN #8 told her that Resident #218 has a history of manic phases and gets in other residents' personal space sometimes. She stated LPN #8 told her that [Resident #219] is being treated for dementia. She stated LPN #8 told her that [Resident #218] had told [LPN #8] that [Resident #219] had pushed him. She stated: "I told her to investigate. And I never got a call back. I did not follow up on Sunday. I did follow up on Monday after the morning meeting. None of the stories matched up." When asked if the allegations and the stories not matching up were not reasons for safety measures to be implemented immediately on 6/25/16 and continuing through the weekend and to the present time, ASM #2 did not respond right away. After a few seconds, she stated: "We have tried to do so much. We have come a long

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way and this is a fluke. We have not had agency nurses in here since that day (6/25/16). This staff is sabotaging itself. It is so hard."

On 6/29/16 at 5:15 p.m., ASM #1, the executive director and administrator of record, ASM #2, ASM #3 and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

A review of the policy entitled "Plans of Care" revealed, in part, the following: "The facility will develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medial, nursing, mental and psychosocial needs that are identified in the comprehensive assessment...the comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."

No further information was provided prior to exit.

(1) "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality and mood problems (depression or mania)." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.
(2) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis

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order/index.shtml.
Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. " A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care. "

2. Resident #219 was admitted to the facility on 10/16/15 with diagnoses including, but not limited to: dementia, major depression, and cognitive communication deficit. On the most recent MDS, an annual assessment with assessment reference date 3/28/16, Resident #219 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS. He was coded with all zeros for indicators of mood difficulties, and as having no behaviors during the look back period. He was coded as requiring supervision assistance (oversight, encouragement or cueing) of staff for walking in his room and in the corridor on the unit, as well as for moving to and returning from off-unit locations.

On 6/28/16 at 4:10 p.m., Resident #219 was

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observed lying on top of his bed with his eyes closed.

On 6/29/16 at 3:30 p.m., Resident #219 was observed ambulating independently from the hallway to his room.

Resident #218 was admitted to the facility on 5/18/15 and most recently readmitted on 9/25/15 with diagnoses including, but not limited to: Schizoaffective disorder (1), bipolar disorder (2), and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 4/13/16, Resident #218 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). He was coded with all zeros for indicators of mood difficulties, and as having no behaviors during the look back period. He was coded as being independent for walking in his room and in the corridor on the unit, and as requiring the supervision assistance (oversight, encouragement or cueing) of staff for moving to and returning from off-unit locations.

A review of the progress notes for Resident #219 revealed the following note written 6/25/16 at 10:00 a.m. by LPN (licensed practical nurse) #9: "Resident in the dining room approached [name of Resident #218 - crossed through with one line] resident and pushed him while [Resident #218] was getting up. [Resident #218] fell. [Resident #219] stated that [Resident #218] was cursing at him. Both residents were separated. Will continue to monitor. All am (morning) meds (medications) given."

Further review of the progress notes for Resident

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#219 revealed no evidence of any follow-up to this incident until notes written on 6/27/16 by ASM (administrative staff member) #2, the regional director of clinical services, [corporate nurse]) and a floor nurse, who was not available for interview.

A review of the progress notes for Resident #218 revealed the following note (unsigned) written on 6/25/16 at 11:00 a.m.: "Resident alert. Found in the dinning (sic) area buttocks on the floor. He appeared anxious and was talking incessantly. All am meds given prior...no c/o (complaints of) pain. No visible injury noted. Re-directed to his room. Neuro (neurological) checks implemented. Provided comfort and safety measure. Informed resident to use call bell to ask for help. Anti-anxiety pill given and encouraged plenty of fluids. RP (responsible party) not answering, left a message to call back. MD (medical doctor) made aware, no order given, just monitor resident."

A review of the comprehensive care plan for Resident #219 initiated 10/29/15 and updated on 4/25/16 revealed no evidence of any interventions related to the 6/25/16 altercation.

A review of a document titled "Witness Statement" dated 6/25/16 and signed by LPN #9 revealed, in part, the following: "10:30 a.m. Interviewed [Resident #218] in his room regarding the incident in the dining room. He stated that he was getting up in the chair when another resident from another table approached him and pushed his shoulders resulting him to fall (sic). He stated also that the resident [name of Resident #219] was angry and insecure. He landed buttocks first. He wasn't doing anything to provoke him at

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that time."

On 6/29/16 at 10:55 a.m., LPN #12 was interviewed regarding anything she saw or heard on the morning of 6/25/16. She stated: "I didn't see anything. I heard [Resident #218] had a fall and the girl did a fall report, or at least she was supposed to." LPN #12 stated she was in charge of caring for Resident #218 on 6/26/16. LPN #12 stated she was not aware of the incident described in the above referenced witness statement. When asked if she was aware of any safety interventions to prevent further altercations between these two residents, she stated: "No."

On 6/29/16 at 11:05 a.m., CNA (certified nursing assistant) #2 was interviewed about the events on the morning of 6/25/16. She stated: "I was not in there (the dining room)." CNA #2 stated she heard that Residents #219 and #218 "got into an altercation and [Resident #219] pushed [Resident #218]." CNA #2 stated she was told to get vital signs on Resident #218. She stated she thought the incident occurred during a meal time. When asked if both residents are able to ambulate independently, CNA #2 stated: "Yes. They were supposed to be separated after that, but I know they can both walk on their own." When asked, since she was assigned to both residents during the current shift, if she was aware of any safety interventions put into place to prevent further altercations, CNA #2 stated: "No. Not right now."

On 6/29/16 at 11:05 a.m., CNA #5 was interviewed about the events of 6/25/16. She stated she did not see or hear anything directly. CNA #5 stated ASM #3, the director of clinical services, came into the building "sometime" that day (6/25/16).

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On 6/29/16 at 11:10 p.m., LPN #11 was asked about the events of 6/25/16. She stated she worked that morning, but did not hear anything "except that [Resident #218] had a fall."

On 6/29/16 at 1:00 p.m., LPN #8, the weekend supervisor working on 6/25/16, was interviewed by telephone. She stated: "The only thing I know is that [Resident #218] had a fall in the dining room Saturday morning." When asked how she became aware of the fall, LPN #8 stated one of the CNAs approached her and told her that Resident #218 was sitting on the floor in the dining room. She stated as she walked down the hallway towards the dining room, she passed Resident #219 exiting the dining room. LPN #8 stated she investigated the fall after breakfast, but there were no witnesses. She stated she completed a facility fall packet. LPN #8 stated later in the evening, Resident #218 complained of pain, and that an X-ray was ordered and obtained, but that the X-ray was negative for any fracture or other pathology. When asked why she was the nurse to complete the fall investigation, LPN #8 stated that the nurse for Resident #218 on that shift was not an employee of the facility, but was a temporary nurse from a nurse staffing agency. LPN #8 stated this nurse (LPN #9) was "still on a med (medication) cart when this happened." LPN #8 stated she assessed the resident for all the normal checks after a fall, including range of motion and neurological issues. LPN #8 stated she instructed LPN #9 to go in and check on Resident #218 once she finished her medication administration. LPN #8 stated: "I got [LPN #9]'s witness statement. I was never able to figure out why he fell." When the surveyor read LPN #9's witness statement to

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her, and asked why this incident, as reported by Resident #218, was not investigated as anything other than an unwitnessed fall, LPN #8 did not respond. When asked if she had read LPN #9's witness statement, LPN #8 stated: "The agency nurse went in and talked to [Resident #218]. He said he was pushed. But he was really manic. No one could substantiate what happened." When asked if anyone interviewed Resident #219 on 6/25/16, LPN #8 stated she tried to talk to him, "but he speaks only Spanish. That is a problem. He speaks only in Spanish. He just kept saying 'I don't love him.'" When asked what the facility staff members have been trained to do in response to the report of a resident to resident incident, LPN #8 stated the staff is supposed to separate the residents, ensure their safety, make sure they are not in the same room and report it to the DCS (director of clinical services). She stated she talked with both ASM #2 and ASM #3 within 15 minutes of the incident. LPN #8 stated: "ASM #2 told me to do an investigation." She continued: "They (Residents #218 and #219) self-separated. [Resident #219] stayed in his room the rest of the day." When asked how she knew this, she stated that she and the other staff "checked on him." LPN #8 went on to say that she worked double shifts (16 hour shifts) on both 6/25/16 and 6/26/16. When informed that other CNAs and nurses who worked that day and on 6/26/16 did not know anything about a need for Resident #219 to stay in his room due to safety concerns, LPN #8 did not respond. When asked if she updated the care plan for either resident, LPN #8 stated: "No, I did not. The floor nurse should do the update." LPN #8 stated that the night shift supervisor working from 6/25/16 to 6/26/16 was made aware of the incident. (This nurse was not available for interview during the

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On 6/29/16 at 1:50 p.m., LPN #4 was interviewed about the process to be followed after a resident to resident incident. She stated that both residents should be assessed and interviewed. She stated that all documentation should be up to date, and that the physician, social worker, supervisor and family should be notified immediately. She stated that the unit managers are responsible for updating care plans on weekdays, and that the weekend supervisors are responsible for updating care plans on the weekend. LPN #4 stated that the incident described in the 6/25/16 notes for Resident #218 and #219 should have been investigated and the care plan revised for both residents. LPN #4 stated that supervision should have been increased for both residents, especially since they are both independently ambulatory.

On 6/29/16 at 1:55 p.m., ASM #3, the director of clinical services, was interviewed about the events of 6/25/16. ASM #3 stated she was called "when it happened." She stated she came to the facility. ASM #3 stated: "You can't interview [Resident #219] because he is Hispanic. There were no injuries. I got witness statements from the staff." When asked from which staff she obtained witness statements, ASM #3 stated: "[LPN #9]." When asked if she obtained any other staff statements, ASM #3 said she did not. She stated: "I did an investigation and wrote it up." At this time, AM #3 provided the surveyor with a typed document dated 6/27/16 and titled "Investigation Synopsis." This document contained neither her name, nor her signature, nor any type of verifiable date stamp. Review of

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this document revealed, in part, the following: "Re: (regarding) possible resident to resident [Resident #218] and [Resident #219]. Methods of Investigation: Resident interview, Staff interview. Summary of findings:...On June 25, 2016 while in dining room when [Resident #218] came into [Resident #219]'s personal space causing [Resident #219] to become angry and pushing [Resident #218] to the floor. Both residents were separated immediately and assessed for injury. An interview was conducted by staff with [Resident #218] whom (sic) at the time was noted to be rambling with his words and noted to be in a heightened state or mania, however was able to state to staff that "The Hispanic man pushed me" during the interview. Resident was assessed no injuries were noted. [Resident #218] complained of back pain and was medicated with prn Tylenol. A physician's order for an x-ray of the cervical area of the back was obtained and the results were negative. [Resident #219] was interviewed by staff but was unable to give details of the incident but did state, "I told him I don't love him and I pushed him down." Both responsible parties and MD (medical doctor) were notified. In conclusion: After investigating the incident that occurred, a psychiatric consult was ordered for both residents because of each resident's altered mental status. Labs (laboratory tests) were also ordered for [Resident #218]. Care plans were also updated to reflect interventions and behaviors." When ASM #3 was asked, again, if the care plans were updated as stated in this document, she stated: "No."

On 6/29/16 at 2:00 p.m., LPN #9 was interviewed by phone. She stated: "The supervisor told me I had to go and interview [Resident #218] after it happened." She stated Resident #218 had been

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"manic" all morning, as demonstrated by talking quickly and nonsensically. She stated Resident #218 told her that when he was standing up in the dining room, Resident #219 approached him and hit him "vehemently and suddenly." When asked for clarification of the adverbs "vehemently and suddenly," she stated these are her interpretations of what Resident #218 told her. She stated that Resident #218 was adamant that Resident #219's actions were quick and violent. She stated that she also attempted to speak with Resident #219. She stated he told her that Resident #218 was cursing at him, acting as though Resident #218 was going to punch him. She stated she reported the results of both these interviews to the supervisor (LPN #8), and that LPN #8 told her to write down her interview with Resident #218 on a fall report witness statement. She stated she was not asked to write down the results of her interview with Resident #219. When asked if, as an agency nurse, she had received any specific training on this facility's procedures to be followed in the case of a report of a resident to resident altercation. She stated she had not received any such education or in-service. She stated her first reaction would be to separate the residents. She stated she had instructed the CNAs working that shift to watch both residents and to "keep an eye on them." When told that none of the CNAs working that day remembered being told to do any sort of special monitoring, she did not respond. When asked if she updated the care plan for either resident, she stated, "No."

On 6/29/16 at 2:15 p.m., LPN #3, who was responsible for both Residents #218 and #219 that day, was interviewed. She stated she was not aware of any interventions put in place to

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keep these residents apart. She stated, "They both walk the halls all the time."

On 6/29/16 at 3:35 p.m., ASM #2, the regional director of clinical services, was interviewed regarding these events. She stated: "I called the facility on that Saturday like I always do on a weekend. I spoke to [LPN #8] and she said, 'We had an incident.'" She stated LPN #8 told her that Resident #218 has a history of manic phases and gets in other residents' personal space sometimes. She stated LPN #8 told her that [Resident #219] is being treated for dementia. She stated LPN #8 told her that [Resident #218] had told [LPN #8] that [Resident #219] had pushed him. She stated: "I told her to investigate. And I never got a call back. I did not follow up on Sunday. I did follow up on Monday after the morning meeting. None of the stories matched up." When asked if the allegations and the stories not matching up were not reasons for safety measures to be implemented immediately on 6/25/16 and continuing through the weekend and to the present time, ASM #2 did not respond right away. After a few seconds, she stated: "We have tried to do so much. We have come a long way and this is a fluke. We have not had agency nurses in here since that day (6/25/16). This staff is sabotaging itself. It is so hard."

On 6/29/16 at 5:15 p.m., ASM #1, the executive director and administrator of record, ASM #2, ASM #3 and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

No further information was provided prior to exit.

(1) "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality and

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(X4) IO PREFIX —TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETIOI OATE
{F 280}	Continued From page 23	{F 280}		

mood problems (depression or mania)." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

(2) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

3. Facility staff failed to update Resident #205's care plan after the 6/22/16 altercation with another resident, Resident #221.

Resident #205 was admitted to the facility on 9/22/09 with diagnoses that included but were not limited to: legally blind, anxiety, depression, osteoarthritis, high blood pressure and arthritis. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/27/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing supervision for activities of daily living. The resident was coded as not having behaviors directed towards others.

Resident #221 was admitted to the facility on 7/24/13 and readmitted on 5/7/15 with diagnoses that included but were not limited to: liver failure, high blood pressure, personality disorder, dementia and depression. The most recent MDS, a quarterly assessment, with an ARD of 5/3/16 coded the resident as having a two of 15 on the

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BIMS indicating the resident was severely impaired cognitively to make daily decisions. The resident was coded as having behaviors not directed towards others.

Review of Resident #205's nurse's note dated 6/22/16 at 11:15 a.m. documented, "Resident noted being involved with another resident in an (sic) physical altercation, this resident states he was rolling to the dining room for lunch when another resident was coming from out of dining room, their wheelchairs collided then the other resident hit this resident in the arms residents were immediately removed from each other the resident (Resident #221) that was hitting was taken back to room, residents (Resident #205) bilateral arms assessed (no) bruising noted @ this time (no) c/o (complaints of pain) (no) s+s (signs and symptoms) discomfort noted while talking (with) resident resident also states the other resident did not hit him hard he is fine was just startled RP (responsible party) + MD (medical doctor) aware."

Review of the resident's care plan dated 6/22/16 documented, "PROBLEM 6/22/2016. propels w/c (wheelchair) (without) assistance risk to run into others. GOAL 6/22/2016 Resident will not roll into others while in w/c." Further review of the care plan did not evidence documentation of an approach or intervention to keep the resident safe from others.

On 6/29/16 at 8:50 a.m. an interview was conducted with RN (registered nurse) #2, the unit manager. When asked about the 6/22/16 altercation, RN #2 stated, "I didn't see it, but the other resident came out of the dining room and bumped into him (Resident #205)." When asked

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{F 280}	Continued From page 25 how this information was documented or shared with staff, RN #2 stated, "I know we gave a verbal report." When asked what the intervention was for the 6/22/16 altercation, RN #2 stated, "I see we've got to see how to keep him safe." On 6/29/16 at 4:05 p.m. with ASM (administrative staff member) #3, the director of nursing. When asked the process staff followed in documenting a resident to resident altercation, ASM #3 stated, "We should be updating the care plan, put it on the 24 hour report. Nurses should be giving report to the CNAs (certified nursing assistants) so they know what to monitor." When asked to review Resident #205's care plan for interventions to keep Resident #205 safe from others, ASM #3 stated, "There's no documentation. I don't see anything." On 6/29/16 at 5:30 p.m. ASM #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing were made aware of the findings. Review of the facility's policy titled "Resident Abuse" documented in part, "Policy: It is inherent in the nature and dignity of each resident at The company that he/she be afforded basic human rights, including the right to be free from abuse, neglect.....Prevention. Monitoring of residents who may be at risk is the responsibility of all facility staff. this included monitoring resident (sic) who are at risk or vulnerable for abuse for indications of changes in behavior...." No further information was provided prior to exit.	{F 280}		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	{F 281}		

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The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide services to meet professional standards for two of 21 residents in the survey sample, Resident #204 and Resident #205.

1. The facility staff dated Resident #204's physician's oxygen order for 6/9/16 when the order had been obtained on 6/28/16.

2. The facility staff dated Resident #205's care plan intervention for 6/22/16 when the care plan had been updated on 6/29/16.

The findings include:

1. Resident #204 was admitted to the facility on 6/7/16 with diagnoses that included but were not limited to: chronic lung disease, congestive heart failure, kidney disease and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 6/14/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. In section O titled "Special Treatment, Procedures, and Programs" the resident was coded as receiving oxygen therapy.

1. Resident #204 is receiving oxygen administration as ordered by the physician. Resident #205 will have a new safety care plan written.
2. Residents currently residing in the facility have the potential to be affected. A review of resident records with orders for oxygen was conducted and all orders are current and oxygen therapy implemented as ordered. There have been no resident to resident altercations.
3. In-servicing has been provided to the licensed nurses by the DCS/designee on proper and accurate documentation to include receiving and transcribing physician orders. MDS Coordinator has in-serviced RDCS and Unit Managers on proper updating of care plans to include timely and accurate updating and acceptable procedure for documenting addendums or late entries. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for

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{F 281}	Continued From page 27 Review of the physician's orders dated 6/9/16 and signed on 6/28/16 at 3:00 p.m. documented, "Oxygen @6L/M (liters/minute) via NC (nasal cannula - soft prongs that fit in the nose to deliver oxygen) continuous." Review of the June 2016 MAR (medication administration record) documented, "Oxygen @ 6 L/M via NC continuous 6/28/16." On 6/29/16 at 8:20 a.m. an interview was conducted with LPN (licensed practical nurse) #10, the nurse who wrote the oxygen order. When asked the process for taking a verbal orders from a physician, LPN #10 stated, "When I take a verbal order, I'm going to write down exactly what's said, make sure it's right and transcribe it to the TAR (treatment administration record) and MAR." When asked to explain the difference in the dates on the oxygen order, LPN #10 stated that on 6/9/16 she had received a verbal order from the physician for the oxygen to be administered at 6 liters per minute. She told the resident's nurse about the order and expected the nurse to write the order (the nurse did not write the order). LPN #10 stated, "It's a clarification order to start off. At the bottom on the POS (physician order set) it was 4 liters, but every time we checked it, it was on six liters from four liters." LPN #10 stated she had asked the resident if he knew how many liters of oxygen he should be on and the resident told her he was to be on six liters. LPN #10 stated she called (name of doctor) on 6/28/16 and told him what she had discovered and (name of doctor) said, "If he's on six and comfortable on six we'll keep him on six." When asked if staff typically back dated orders, LPN #10 stated, "Because I knew we had had that discussion with (name of doctor) on	{F 281}	three (3) months to ensure oxygen orders are transcribed properly and timely. All incidents will be reviewed and discussed in morning meeting and the MDS Coordinator will ensure that interventions have been added to the care plan in a timely manner with the accurate date of implementation. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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admission I felt it was justifiable." When asked if it was a nursing standard of practice to back date physician orders, LPN #10 did not reply.

On 6/29/16 at 8:40 a.m. an interview was conducted with RN (registered nurse) #2, the unit manager, regarding the process staff followed for taking verbal physician orders. RN #2 stated, "Repeat it to the doctor, write it on the order sheet and transcribe it to the MAR and TAR. Let the RP (responsible party) know." When asked if it was a nursing standard of practice to back date orders, RN #2 stated, "No."

On 6/29/16 at 1:35 p.m. an interview was conducted with ASM (administrative staff member) #2, the regional director of clinical services. When asked the process staff followed for taking a verbal order from a physician, ASM #2 stated, "Write down the order, read it back to the doctor and make sure it's accurate. Date it and time it..." ASM #2 was asked when it was acceptable to back date an order. ASM #2 stated, "If I forgot to write an order when it was given to me I would call the doctor back and get a new one." When asked what date would be used, ASM #2 stated, "The current date." ASM #2 was made aware of the findings at that time. A request for the nursing standards the facility used was made at this time; ASM #2 stated that they did not have one.

Review of the facility's policy titled, "Medical Care/Standards of Practice" did not evidence documentation for back dating orders.

On 6/29/16 at 5:30 p.m. ASM #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of

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nursing (director of clinical services) were made aware of the findings.

No further information was provided prior to exit.

"Don't alter a client's record, this is a criminal offense. Never add information at a later date without indicating that you did so. Never document anything that you did not do." Lippincott Williams and Wilkins Fundamentals of Nursing 2007 page 53.

2. Resident #205 was admitted to the facility on 9/22/09 with diagnoses that included but were not limited to: legally blind, anxiety, depression, osteoarthritis, high blood pressure and arthritis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/27/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing supervision for activities of daily living. The resident was coded as not having behaviors directed towards others.

Review of Resident #205's nurse's note dated 6/22/16 at 11:15 a.m. documented, "Resident noted being involved with another resident in an (sic) physical altercation, this resident states he was rolling to the dining room for lunch when another resident was coming from out of dining room, their wheelchairs collided then the other resident hit this resident in the arms residents were immediately removed from each other the resident that was hitting was taken back to room,

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{F 281}	Continued From page 30	{F 281}		

residents bilateral arms assessed (no) bruising noted @ this time (no) c/o (complaints of pain) (no) s+s (signs and symptoms) discomfort noted while talking (with) resident resident also states the other resident did not him hard he is fine was just startled RP (responsible party) + MD (medical doctor) aware."

Review of the resident's care plan dated 6/22/16 documented, "PROBLEM 6/22/2016. propels w/c (wheelchair) (without) assistance risk to run into others. GOAL 6/22/2016 Resident will not roll into others while in w/c." Further review of the care plan did not evidence documentation of an approach or intervention to keep the resident safe from others.

On 6/29/16 at 8:50 a.m. an interview was conducted with RN (registered nurse) #2, the unit manager. When asked about the 6/22/16 altercation, RN #2 stated, "I didn't see it, but the other resident came out of the dining room and bumped into him (Resident #205)." When asked how this information was documented or shared with staff, RN #2 stated, "I know we gave a verbal report." When asked what the intervention was for the 6/22/16 altercation, RN #2 stated, "I see we've got to see how to keep him safe."

On 6/29/16 at 1:15 p.m., RN #2 returned with Resident #205's care plan. On the care plan was documented, "APPROACHES & INTERVENTIONS. 6/22/16 staff to transport res. (resident) off unit." When asked when the intervention had been added to the care plan, RN #2 stated, "(ASM #2) added it today." When asked if it was a nursing standard to back date documentation RN #2 stated that it was not.

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{F 281}	Continued From page 31 On 6/29/16 at 1:55 p.m. an interview was conducted with ASM #2, the regional director of clinical services. When asked about Resident #205's back dated care plan, ASM #2 stated, "(Name of RN #2) brought it to me." When asked if the care plan had been updated on 6/29/16 but dated for 6/22/16, ASM #2 stated it was. On 6/29/16 at 5:30 p.m. ASM #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing (director of clinical services), were made aware of the findings. A request for the facility's nursing standards was made at this time; ASM #2 stated there were no manuals. On 6/30/16 at 8:10 a.m. ASM #2 met with the three surveyors. ASM #2 stated that her unit manager was young and she had come to her and told her that she thought this surveyor was giving them a "freebie" for the interventions for the resident. ASM #2 stated she knew better than that but that is why they post dated the intervention on Resident 205's care plan. No further information was provided prior to exit.	{F 281}		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	{F 282}	1. Resident #212 has a behavioral monitoring record. Resident #214 has a behavioral monitoring record. Resident #203 and # 206 are having oxygen administered as ordered. Resident #213 is wearing ted hose as ordered by MD.	7/27/2016

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{F 282}	Continued From page 32 document review and clinical record review it was determined that facility staff failed to follow the plan of care for five of 21 residents in the survey sample, Resident #212, Resident #214, Resident #203, Resident #206 and Resident #213. 1. The facility staff failed to implement behavior monitoring for Resident #212 as per the care plan implemented on 3/3/16 and updated on 5/26/16. 2. The facility staff failed to implement behavior monitoring for Resident #214 as per the care plan implemented on 5/9/16. 3. The facility staff failed to administer oxygen per the plan of care for Resident # 203. 4. The facility staff failed to administer oxygen per the plan of care for Resident # 206. 5. The facility staff failed to follow the plan of care for Resident #213 when they did not apply TED (1) hose on 6/29/16. The findings include: 1. Resident #212 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to: dementia, anxiety, psychosis and bipolar disease (1). The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/24/16, coded the resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively to make daily decisions. In section E titled, Behavior, the resident was coded as wandering for one to three	{F 282}	2. Residents currently residing in the facility have the potential to be affected. Resident were reviewed and residents with orders for oxygen and ted hose were observed and devices were in place. Residents with a need for behavior monitoring were reviewed and behavior monitoring forms are in place. 3. DCS/designee will in-service nursing staff /on regulations for administration of oxygen and following the residents plan of care. Nursing staff will also be in-serviced on the behavioral policy as it relates to monitoring behaviors and documentation. In-servicing will be provided to the nursing staff and nursing assistants on donning and removing ted hose as per MD order. DCS/designee will perform random observations 5 times weekly for 3 months to ensure that oxygen therapy is being provided as per MD order and plan of care. DCS/designee will conduct random audits weekly x 3 months to ensure that residents with behaviors have a current behavior monitoring sheet to identify behaviors. Random observations will be conducted weekly x 3 months to ensure residents with orders for ted hose are being applied as ordered.	

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days in the look back period. The resident was coded as requiring supervision to assistance of one staff member for activities of daily living.

Review of Resident #212's plan implemented on 5/9/16 documented, "Focus: Impaired or inappropriate behaviors. As Evidenced By: Wandering. APPROACHES & INTERVENTIONS. Monitor behavioral symptoms...."

Review of Resident #212's behavior monitoring flow record did not evidence documentation of targeted behaviors or that behaviors had been monitored.

Review of the nurse's notes from 6/22/16 to 6/30/16 did not evidence documentation related to behavior.

On 6/29/16 at 3:30 p.m. an interview was conducted with LPN #11. When asked who used the care plan, LPN #11 stated, "The nursing staff, the charge nurses, the unit manager and MDS (coordinators)." When asked why they had care plans, LPN #11 stated, "So when issues that arise with the resident we are all on the same page." When asked if staff should follow the care plan, LPN #11 stated, "I think it's very important, it (the care plan) should be accurate so everyone's on the same page to get to the same goal."

Review of the facility's policy titled, "Plans of Care" documented in part, "Procedure: Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary.

{F 282}

4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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On 6/29/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing were made aware of the findings.

(1) Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

2. Resident #214 was admitted to the facility on 3/31/08 with diagnoses that included but were not limited to: Alzheimer's disease, high blood pressure, dementia and anxiety.

The most recent MDS, a quarterly assessment, with an ARD of 5/13/16 coded the resident as having rarely make self understood and rarely able to understand others. In section E, titled Behavior, the resident was coded as wandering on a daily basis. The resident was coded as requiring supervisor to one person assist for activities of daily living.

Review of Resident #214's care plan titled, "Behavior/Mood" documented in part, "Focus: Impaired or inappropriate behaviors. As Evidenced By: Wandering. 5/23/16 aggression towards other residents. APPROACHES AND INTERVENTIONS. Monitor behavioral symptoms...."

Review of Resident #214's June 2016 behavior monitoring flow record did not evidence documentation of targeted behaviors or that the

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behaviors had been monitored.

Review of the nurse's notes did not evidence documentation from 6/22/16 to 6/30/16.

On 6/29/16 at 3:30 p.m. an interview was conducted with LPN #11. When asked who used the care plan, LPN #11 stated, "The nursing staff, the charge nurses, the unit manager and MDS (coordinators)." When asked why they had care plans, LPN #11 stated, "So when issues that arise with the resident we are all on the same page." When asked if staff should follow the care plan, LPN #11 stated, "I think it's very important, it (the care plan) should be accurate so everyone's on the same page to get to the same goal."

On 6/29/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing were made aware of the findings.

3. Resident # 203 was admitted to the facility on 10/26/12 and most recently readmitted on 2/23/13 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, convulsions, depression, peripheral vascular disease, coronary artery disease, hypertension, hyperlipidemia, atrial fibrillation, abdominal aortic aneurysm, glaucoma, diabetes, and kidney disease.

Resident # 203's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/3/16, coded Resident # 203 as usually understood by others and usually understanding others. Resident # 203 was coded as scoring 10 of a possible 15 on

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the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired. Section O documented the resident received oxygen therapy during the last 14 days.

Review of Resident # 203's clinical record revealed physician orders with a start date of 4/15/13 that were most recently signed by the physician on 6/10/16. The physician order documented: "O2 @ 2L VIA NASAL CANNULA CONTINUOUS HUMIDIFIED FOR SHORTNESS OF BREATH " (oxygen at 2 liters per minute).

Resident # 203's comprehensive care plan initiated on 4/1/14 and revised 9/15/14 documented, under "PROBLEM" "Focus Category: Cardiovascular" Under "APPROACHES & INTERVENTIONS...Administer oxygen as ordered." "IMP (implementation) DATE 4/13/16." Another care plan initiated 4/1/14 and revised 9/15/14 documented: under "PROBLEM" "Focus Category: Respiratory" Under "APPROACHES & INTERVENTIONS...Oxygen as ordered (specify route, device, and liter flow) O2 via N/C @ 2LPM (liters per minute)." "IMP DATE 4/13/16."

Resident # 203 was observed on 6/28/16 at approximately 11:45 a.m. and again on 6/28/16 at 3:55 p.m. During each of these observations Resident # 203 was receiving oxygen via a nasal cannula and the oxygen concentrator was set at 1 and 3/4 liters per minute as evidenced by the bottom the ball in the concentrator flow meter resting on the 1 ½ liter mark and the top just touching the 2 liter mark.

During an interview and observation of Resident #

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203's oxygen on 6/28/16 at 4:20 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 confirmed the oxygen flow meter had the bottom of the ball resting on the 1½ (1.5) liter mark. LPN # 2 stated that she would have to check the physician's order. LPN # 2 returned stating that the order was for 2LPM (liter per minute).

During an interview on 6/28/16 at 4:35 p.m. with ASM (administrative staff member) # 1, the administrator and ASM # 2, the regional director of clinical services [corporate nurse], the finding of the incorrectly set oxygen was revealed. At this time a request was made for the facility policy.

Review of the facility policy "Oxygen Therapy" Under "PROCEDURE: 1. Review physician's order...9. Start O2 flowrate at the prescribed liter flow..."

Review of the manufacturer's User Manual revealed the following: Page 19. "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

During an interview on 6/30/16 at 9:10 a.m. with LPN # 13, LPN # 13 stated that when she gets a new order or intervention she updates the care plan. LPN # 13 further stated that she uses the care plan as a tool and that she finds it very useful.

During an interview on 6/30/16 at 9:20 a.m. with LPN # 1, LPN # 1 stated that the care plans are updated with interventions and nurses get information from the care plan. LPN # 1 further

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stated that the care plan is used but the physician order should also be checked.

During an interview on 6/30/16 at approximately 10:00 a.m. with ASM # 1 and ASM # 2, the concern of not following the plan of care was revealed and a copy of the policy for care plans was requested.

A review of the facility policy entitled "Plans of Care" revealed, in part, the following: "An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on as as-needed basis...The resident's plan of care encompasses many documents that are part of the resident's clinical record and may include, not only structured care plan documents, but may also include MARS (medication administration records), TARS (treatment administration records), physician orders, flow records, and/or legal documents that would drive the plan of care for the individual resident....Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary."

No further information was presented prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs,

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and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

4. Resident # 206 was admitted to the facility on 7/29/15 and most recently readmitted on 5/16/16 with diagnoses that included but were not limited to: chronic respiratory failure, convulsions, quadriplegia, Down Syndrome, dementia, gastro-esophageal reflux disease, neurogenic bladder, and hypertension.

Resident # 206's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/16, coded Resident # 206 as never/rarely understood by others and never/rarely understanding others. Resident # 206 was coded as severely impaired for Cognitive Skills for Daily Decision Making in Section C, Cognitive Patterns.

Review of Resident # 206's clinical record

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revealed a telephone order dated and signed on 6/3/16 by the physician that documented: "O2 @ 2.5 ml/min. Via Trach to equal 30% oxygen, 20 PSI, 80 % humidifier Q shift." This order again appeared on the Physician Order Sheet and was signed by the physician on 6/6/16. NOTE: O2 = oxygen; @ = at; ml = milliliters; trach = tracheostomy (tube in an opening in windpipe to support breathing); PSI = pounds per square inch (pressure at which oxygen is delivered); Q = every.

Resident # 206's comprehensive care plan initiated on 4/1/14 and revised 9/15/14 documented, under "PROBLEM" "Focus Category: Cardiovascular" dated 8/11/15. Under: "APPROACHES & INTERVENTIONS...Administer oxygen as ordered."

Observations of Resident # 206's oxygen equipment were made on the following dates and times:

- 6/28/16 at on initial tour at approximately 11:30 a.m. O2 flow meter was set to 3L/min. (ball centered on 3L line)
- 6/28/16 at 3:50 p.m. O2 flowmeter was set to 3 L/min. (ball centered on 3L line)
- 6/29/16 at 8:00 a.m. O2 flowmeter was set to 2 ¼ L/min (bottom of ball sitting on 2L line with top of ball at the 2.5 L line)
- 6/29/16 at 9:29 a.m. O2 flow meter was set to 2 ¾ L/min. (bottom of ball sitting on 2.5 L line with top of ball on the 3 L line)
- 6/29/16 at 10:10 a.m. O2 flow meter was set to 2.5 L/min and Humidity was set to 28% (instead of the ordered 80 %)
- 6/29/16 at 12:58 p.m. O2 flowmeter was set

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tɒ 2.5 L/min and Humidity was set to 28% (instead of the ordered 80 %) [This was also observed by LPN (licensed practical nurse) # 3 on 6/29/16 at 12:58p.m.]

· 6/29/16 at 1:05 p.m. O2 flɒw meter was set to 2.5 L/min and Humidity was set to 28 % (instead ɒf the ɒrdered 80 %) [This was also observed by LPN # 4, the unit manager ɒn 6/29/16 at 1:05 p.m.]

Review of the manufacturer's User Manual revealed the following: Page 19. "NOTE: To properly read the flowmeter, lɒcate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

During an interview on 6/29/16 at 12:58 p.m. with LPN # 3 Resident # 206's oxygen equipment was observed. The O2 flow meter read 2.5 L/min (as ordered) and the humidity read 28 % (80% being the ordered amount). LPN # 3 agreed with the reading and went to check the physician order.

During an interview on 6/29/16 at 1:05 p.m. with LPN # 4, LPN # 4 came into the room and adjusted the humidity setting to 80%. When asked what the reading was before she (LPN # 4) adjusted the setting she stated that it was set tɒ 28%.

During an interview on 6/29/16 at 1:07 p.m. with LPN # 3, LPN # 3 stated that she had not adjusted any of the settings on Resident # 206's oxygen equipment.

During an interview on 6/29/16 at 1:20 p.m. these observations were shared with ASM

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(administrative staff member) # 2, the corporate nurse, and a request was made for any policy or information on Resident # 206's oxygen equipment.

During an interview on 6/29/16 at 2:50 p.m. with LPN # 4, LPN # 4 suggested that perhaps the Resident's brother had adjusted the O2 settings. At this time a request was made for any documentation to corroborate that assertion; nurse's notes, care plan, education of family. Prior to exit no documentation was provided. At this time LPN # 4 was asked explain how one would read the oxygen flow meter. LPN # 4 stated that one would get down to eye level and that the ball should be centered on the line of the prescribed flow rate.

During an interview on 6/29/16 at 3:50 p.m. with Resident # 206's brother, the brother was asked, "Have you ever touched your brother's (Resident # 206) oxygen equipment." The brother answered, "No, I do not."

During an interview on 6/29/16 at 4:00 p.m. with LPN # 3, LPN # 3 stated, "I knew it was supposed to be on 80 %, I saw that it was on 28 % I went out to read the chart and the (name of LPN # 4) came in and she fixed it. I do not know how it got to be set on 28 %. I have been going in more frequently since then to check and it has been correct each time."

Review of the facility policy "Oxygen Therapy" Under "PROCEDURE: 1. Review physician's order...7. Attach humidifier or nebulizer to flowmeter, if indicated. 8. Attach administration device to flowmeter or humidifier/nebulizer outlet.

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{F 282}	Continued From page 43 9. Start O2 flowrate at the prescribed liter flow..." Review was made of the educational information provided by ASM # 2 titled "High Humidity Set-Ups Utilizing Liquid Oxygen and /or Concentrator with Air Compressor." ASM # 2 stated that this was the educational information provided to nurses. The educational information was a one page diagram and in the bottom right hand corner was an inset showing how to adjust the humidification. "Match pointer with notch on Jet Nebulizer Dial at 80%." During an interview on 6/30/16 at 9:10 a.m. with LPN # 13, LPN # 13 stated that when she gets a new order or intervention she updates the care plan. LPN # 13 further stated that she uses the care plan as a tool and that she finds it very useful. During an interview on 6/30/16 at 9:20 a.m. with LPN # 1, LPN # 1 stated that the care plans are updated with interventions and nurses get information from the care plan, LPN # 1 further stated that the care plan is used but the physician order should also be checked. During an interview on 6/30/16 at approximately 10:00 a.m. with ASM # 1 and ASM # 2, the concern of not following the plan of care was revealed and a copy of the policy for care plans was requested. No further information was presented prior to exit. 5. Resident #213 was admitted to the facility on 9/1/15 with diagnoses including, but not limited to: dementia with behaviors and high blood pressure.	{F 282}		

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On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/10/16, Resident #213 was coded as being severely cognitively impaired for making daily decisions; having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of one staff member for dressing.

On the following date and times, Resident #213 was observed sitting in her wheelchair in the dining room, without TED hose (1) applied: 6/29/16 at 8:10 a.m., 11:50 a.m., 1:15 p.m., and 2:45 p.m.

A review of the clinical record revealed the following order dated 3/1/16: "TED hose on at every morning off at bedtime for edema (swelling)."

A review of the comprehensive care plan for Resident #213 dated 2/15/16 revealed, in part, the following: "Cardiovascular problem: Edema. TED hose as ordered."

On 6/29/16 at 2:45 p.m., CNA (certified nursing assistant) #1 was interviewed regarding any items Resident #213 should have been wearing. CNA #1 accompanied the surveyor to observe Resident #213. After observing the resident, CNA #1 stated: "She was already dressed when I got her this morning. I just checked her when I got here." When asked directly if the resident was supposed to wear anything on her legs, CNA #1 stated: "To tell you the truth, I don't know. I just check her to make sure she is not wearing any extra clothing. She likes to put on lots of different clothes on top of each other." When asked if she was aware of what the care plan

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stated that Resident #213 should be wearing on her legs, CNA #1 stated: "No. I'm sorry. I'm not."

On 6/29/16 at 3:05 p.m., LPN (licensed practical nurse) #10 was asked to accompany this surveyor to observe Resident #213. When asked if the resident was wearing TED hose, LPN #10 stated: "No she is not. But I'm not sure she is supposed to. I'll need to check the order." The surveyor accompanied LPN #10 to check the order on the resident's chart. LPN #10 stated: "My usual procedure is that the TED hose get put on with morning care. They should have been put on this morning by the CNA, or I should have been told if she had refused them or something." When asked how she communicates a resident's care plan needs to CNAs, she stated: "I never work over here. I'm just filling in today. I thought these CNAs knew these residents better than me."

On 6/29/16 at 5:15 p.m., ASM #1, the executive director and administrator of record, ASM #2, the regional director of clinical services, ASM #3, the director of nursing (also known as the director of clinical services), and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

A review of the facility policy entitled "Plans of Care" revealed, in part, the following: "Direct care staff should be aware, understand and follow their Resident's plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary."

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{F 282}	Continued From page 46 No further information was provided prior to exit. (1)"TED (thromboembolic device) hose are compression stockings. You wear compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots." This information was taken from the website http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000597.htm . In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care to promote the highest level of well-being for two of 21 residents in the survey	{F 309}		

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sample, Resident #204 and Resident #213.

1. The facility staff failed to assess and re-assess Resident #204's pain level on 6/26/16 at 2:30 p.m. and failed to re-assess the resident's pain on 6/27/16 at 1:30 a.m.

2. The facility staff failed to apply physician-ordered TED (1) hose for Resident #213 on 6/29/16.

The findings include:

1. Resident #204 was admitted to the facility on 6/7/16 with diagnoses that included but were not limited to: chronic lung disease, congestive heart failure, kidney disease and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 6/14/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. In section JO300 through JO600, titled, "Pain Presence" the resident was coded as having pain frequently and that the pain limited day to day activities. The pain was rated a seven on a scale of zero to ten with ten being the worst pain imaginable.

Review of Resident #204's care plan implemented 6/20/16 titled, "Pain/Comfort" documented in part, "Monitor pain characteristics (frequency) Qshift (every shift) and PRN (as needed): ...Severity (1 to 10 scale)..."

Review of the physician's orders dated 7/1/16 documented, "OXYCODONE HCL

1. For resident #204 had a pain assessment completed current medication is effective. Resident #213 is wearing TED hose as ordered by MD.
2. Pain assessments will be conducted for residents receiving pain medications to ensure therapy is appropriate and documentation is in place. Observations were conducted and TED hose were being worn for residents with orders.
3. Licensed nurses will be in-serviced on ensuring pain assessments are completed prior to and after administering pain medications and monitoring the effectiveness of as needed pain medication.

Random weekly reviews will be conducted for five (5) residents weekly for three (3) months by the DCS/designee for the following: a) ensuring pain assessments are completed including quality descriptors prior to administering as needed pain medications and monitoring the effectiveness of the pain medication b) residents with physician orders for TED hose will be observed weekly x 3 months to ensure compliance with therapy.

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(hydrochloride) (1) 5MG (milligram)TABLET...TAKE 1 TAB (tablet) TWICE DAILY AS NEEDED FOR PAIN"

Review of the MAR (medication administration record) for 6/26/16 at 2:30 p.m. documented, "Oxycodone 5mg PO (by mouth) c/o (complains of) foot/leg pain." There was no documentation regarding the resident's pain assessment or reassessment. Further review of the MAR for 6/27/16 at 1:30 a.m. documented, "Oxycodone 5mg PO c/o foot pain. 8/10 (pain rated as an eight out of ten)." There was no follow up assessment of the effectiveness of the medication documented.

Review of the nurse's notes for 6/26/16 and 6/27/16 did not evidence documentation regarding the resident's complaint of pain.

On 6/29/16 at 4:35 p.m. an interview was conducted with LPN (licensed practical nurse) #15, regarding the process staff follow when giving a resident pain medication. LPN #15 stated, "Ask them a score between one to ten, one being the least and ten being the most and what kind, aching, throbbing, stabbing, how long it's been going on. Document that you gave the pain med (medication) and the go back and check on the resident, usually in 30 minutes to an hour." When asked why the resident was re-checked, LPN #15 stated, "If it's not working we need to contact the doctor." When asked to review the MAR from 6/26/16 and 6/27/16, LPN #15 stated, "No, she didn't document it (the pain scale rating)."

On 6/29/16 at 4:40 p.m. an interview was conducted with LPN #10. When asked to review

4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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the MAR from 6/26/16 and 6/27/16, LPN #10 stated, "I guess we didn't ask him what his pain level was." When asked if that was part of the pain assessment, LPN #10 stated that it was.

On 6/29/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing [director of clinical services], were made aware of the findings.

Review of the facility's policy titled, "Pain Management" documented, "Procedure: Considerations: A pain assessment are (sic) done on admission, quarterly, and as indicated by the pain level of the resident. Process. Whenever possible, obtain all information from the resident. Use a pain scale when the resident describes his or her pain and amount of pain relief. A pain scale of o (sic) to 10 can be used with residents who can understand the concept. In treating pain, the following is recommended: Reassess and document the resident's pain using an appropriate pain scale every shift after narcotic medication has started if the dose has changed or if the drug has changed until the resident's pain is under control."

No further information was provided prior to exit.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may

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bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management.

2. Resident #213 was admitted to the facility on 9/1/15 with diagnoses including, but not limited to: dementia with behaviors and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/10/16, Resident #213 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of one staff member for dressing.

On the following date and times, Resident #213 was observed sitting in her wheelchair in the dining room, without TED hose (1) applied: 6/29/16 at 8:10 a.m., 11:50 a.m., 1:15 p.m., and

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2:45 p.m.

A review of the clinical record revealed the following order dated 3/1/16: "TED hose on at every morning off at bedtime for edema (swelling)."

A review of the comprehensive care plan for Resident #213 dated 2/15/16 revealed, in part, the following: "Cardiovascular problem: Edema. TED hose as ordered."

On 6/29/16 at 2:45 p.m., CNA (certified nursing assistant) #1 was interviewed regarding any items Resident #213 should have been wearing. CNA #1 accompanied the surveyor to observe Resident #213. After observing the resident, CNA #1 stated: "She was already dressed when I got her this morning. I just checked her when I got here." When asked directly if the resident was supposed to wear anything on her legs, CNA #1 stated: "To tell you the truth, I don't know. I just check her to make sure she is not wearing any extra clothing. She likes to put on lots of different clothes on top of each other." When asked if she was aware of what the care plan stated that Resident #213 should be wearing on her legs, CNA #1 stated: "No. I'm sorry. I'm not."

On 6/29/16 at 3:05 p.m., LPN (licensed practical nurse) #10 was asked to accompany this surveyor to observe Resident #213. When asked if the resident was wearing TED hose, LPN #10 stated: "No she is not. But I'm not sure she is supposed to. I'll need to check the order." The surveyor accompanied LPN #10 to check the order on the resident's chart. LPN #10 stated: "My usual procedure is that the TED hose get put

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on with morning care. They should have been put on this morning by the CNA, or I should have been told if she had refused them or something." When asked how she communicates a resident's care plan needs to CNAs, she stated: "I never work over here. I'm just filling in today. I thought these CNAs knew these residents better than me."

On 6/29/16 at 5:15 p.m., ASM #1, the executive director and administrator of record, ASM #2, the regional director of clinical services, ASM #3, the director of nursing (also known as the director of clinical services), and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

A review of the facility policy entitled "Plans of Care" revealed, in part, the following: "Direct care staff should be aware, understand and follow their Resident's plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary."

On 6/30/16 at 8:30 a.m., ASM #2 told the surveyor that the facility did not have a policy on TED hose.

No further information was provided prior to exit.

(1)"TED (thromboembolic device) hose are compression stockings. You wear compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots." This information was taken from the website

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{F 309}	Continued From page 53 http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000597.htm . In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	{F 309}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide a safe environment for two of 21 residents in the survey sample, Residents #218 and #205. 1. The facility staff failed to develop and implement interventions to keep Resident #218 safe between 6/25/16 and 6/27/16 after an altercation between him and Resident #219. 2. The facility staff failed to develop and	{F 323}	1. Resident #218, #219, #205 have care plans with appropriate safety interventions. 2. Residents currently residing in the facility have the potential to be affected. There have been no resident to resident altercations since 6/25/16. 3. In-servicing will be provided to the nursing staff to include the supervisors by the MDS Coordinator/designee on updating resident's plan of care with appropriate safety interventions immediately following any incidents. Daily reviews will be conducted of care plans during morning meeting for all incidents to ensure immediately interventions have been put in place and are appropriate X (3) months.	7/27/2016

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implement interventions to keep Resident #205 safe following the 6/22/16 altercation with another resident.

The findings include:

1. Resident #218 was admitted to the facility on 5/18/15 and most recently readmitted on 9/25/15 with diagnoses including, but not limited to: Schizoaffective disorder (1), bipolar disorder (2), and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 4/13/16, Resident #218 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). He was coded with all zeros for indicators of mood difficulties, and as having no behaviors during the look back period. He was coded as being independent for walking in his room and in the corridor on the unit, and as requiring the supervision assistance (oversight, encouragement or cueing) of staff for moving to and returning from off-unit locations.

On 6/29/16 at 8:05 a.m., Resident #218 was observed in the dining room eating breakfast. He was alert. He spoke rapidly, and his speech was unintelligible to this surveyor. He spoke to the surveyor, to his table mates and to surrounding staff. He alternated outbursts of speech with eating his breakfast.

On 6/29/16 at 4:05 p.m., Resident #218 was observed sitting in the dining room alone. No other residents were around him.

On 6/30/16 at 8:55 a.m., Resident #218 was

4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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observed walking independently into the dining room, speaking to staff, looking around, and taking a seat at a table to which the staff led him. His speech was intelligible, as he spoke about breakfast.

Resident #219 was admitted to the facility on 10/16/15 with diagnoses including, but not limited to: dementia, major depression, and cognitive communication deficit. On the most recent MDS, an annual assessment with assessment reference date 3/28/16, Resident #219 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS. He was coded with all zeros for indicators of mood difficulties, and as having no behaviors during the look back period. He was coded as requiring supervision assistance (oversight, encouragement or cueing) of staff for walking in his room and in the corridor on the unit, as well as for moving to and returning from off-unit locations.

On 6/28/16 at 4:10 p.m., Resident #219 was observed lying on top of his bed with his eyes closed.

On 6/29/16 at 3:30 p.m., Resident #219 was observed ambulating independently from the hallway to his room.

A review of the progress notes for Resident #219 revealed the following note written 6/25/16 at 10:00 a.m. by LPN (licensed practical nurse) #9: "Resident in the dining room approached [name of Resident #218 - crossed through with one line] resident and pushed him while [Resident #218] was getting up. [Resident #218] fell. [Resident #219] stated that [Resident #218] was cursing at

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him. Both residents were separated. Will continue to monitor. All am (morning) meds (medications) given."

Further review of the progress notes for Resident #219 revealed no evidence of any follow-up to this incident until notes written on 6/27/16 by ASM (administrative staff member) #2, the regional director of clinical services [corporate nurse]) and a floor nurse, (who was not available for interview).

A review of the progress notes for Resident #218 revealed the following note (unsigned) written on 6/25/16 at 11:00 a.m.: "Resident alert. Found in the dinning (sic) area buttocks on the floor. He appeared anxious and was talking incessantly. All am meds given prior...no c/o (complaints of) pain. No visible injury noted. Re-directed to his room. Neuro (neurological) checks implemented. Provided comfort and safety measure. Informed resident to use call bell to ask for help. Anti-anxiety pill given and encouraged plenty of fluids. RP (responsible party) not answering, left a message to call back. MD (medical doctor) made aware, no order given, just monitor resident."

Further review of the clinical record for Resident #218 revealed the following note dated 6/25/16 at 7:00 p.m. and signed by a floor nurse who was not available for interview: "Resident came to writer and stated that his upper back was hurting. Asked resident what level on a scale of 1-10 and he stated 12. Called MD and he stated to get X-ray of upper back and start Tylenol extra strength 1 tab po (by mouth) q6h (every six hours) prn (as needed). [Name of mobile X-ray company] notified and will be in facility within the

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hour. Neuro (neurolbgical) checks in place and within NL (normal limits)."

A review of the X-ray results for the above ordered upper back X-ray for Resident #218 revealed no evidence of the finding of any abnormalities or fractures.

A review of the comprehensive care plan for Resident #219 initiated 10/29/15 and updated on 4/25/16 revealed no evidence of any interventions related to the 6/25/16 altercation.

A review of the comprehensive care plan for Resident #218 dated 4/6/16 revealed, in part, the following updates made on 6/25/16: "Neuro checks. X-ray of back. Rehab (rehabilitation services) referral." The review revealed no interventions related to the altercation on 6/25/16 and Resident #218's continued safety from physical altercations with Resident #219 and other residents.

A review of facility document entitled "Fall Root Cause Investigation Report" for Resident #218 dated 6/25/16 and signed by LPN #8 the weekend supervisor on duty on 6/25/16 revealed, in part, the following: "Locomotion Status: ambulates (walks) /indept (independent)...Unusual circumstances past 24 hours contributing to fall risks?: increased manic behavior...Identified Behaviors: agitation. Identified patterns of Behaviors (specify): [arrow pointing up] behavior...Resident found sitting on his buttocks in dinning (sic) room. Resolution/intervention for minimizing future occurrences: med (medication) review, neuro checks, rehab referral."

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A review of a document entitled "Witness Statement" dated 6/25/16 and signed by LPN #9 revealed, in part, the following: "10:30 a.m. Interviewed [Resident #218] in his room regarding the incident in the dining room. He stated that he was getting up in the chair when another resident from another table approached him and pushed his shoulders resulting him to fall (sic). He stated also that the resident [name of Resident #219] was angry and insecure. He landed buttocks first. He wasn't doing anything to provoke him at that time."

On 6/29/16 at 10:55 a.m., LPN #12 was interviewed regarding anything she saw or heard on the morning of 6/25/16. She stated: "I didn't see anything. I heard [Resident #218] had a fall and the girl did a fall report, or at least she was supposed to." LPN #12 stated she was in charge of caring for Resident #218 on 6/26/16. She stated she was not aware of the incident described in the above referenced witness statement. When asked if she was aware of any safety interventions to prevent further altercations between these two residents, she stated: "No."

On 6/29/16 at 11:05 a.m., CNA (certified nursing assistant) #2 was interviewed about the events on the morning of 6/25/16. She stated: "I was not in there (the dining room)." She stated she heard that Residents #219 and #218 "got into an altercation and [Resident #219] pushed [Resident #218]." She stated she was told to get vital signs on Resident #218. She stated she thought the incident occurred during a meal time. When asked if both residents independently ambulate within the facility, CNA #2 stated: "Yes. They were supposed to be separated after that, but I know they can both walk on their own." When

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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asked, since she was assigned to both residents during the current shift, if she was aware of any safety interventions put into place to prevent further altercations, CNA #2 stated: "No. Not right now."

On 6/29/16 at 11:05 a.m., CNA #5 was interviewed about the events of 6/25/16. She stated she did not see or hear anything directly. She stated that ASM (administrative staff member) #3, the director of clinical services [director of nursing], came into the building "sometime" that day (6/25/16).

On 6/29/16 at 11:10 p.m., LPN #11 was asked about the events of 6/25/16. She stated she worked that morning, but did not hear anything "except that [Resident #218] had a fall."

On 6/29/16 at 1:00 p.m., LPN #8, the weekend supervisor working on 6/25/16, was interviewed by telephone. She stated: "The only thing I know is that [Resident #218] had a fall in the dining room Saturday morning." When asked how she became aware of the fall, LPN #8 stated one of the CNAs approached her and told her that Resident #218 was sitting on the floor in the dining room. She stated as she walked down the hallway towards the dining room, she passed Resident #219 exiting the dining room. LPN #8 stated she investigated the fall after breakfast, but there were no witnesses. She stated she completed a facility fall packet. LPN #8 stated later in the evening, Resident #218 complained of pain, and that an X-ray was ordered and obtained, but that the X-ray was negative for any fracture or other pathology. When asked why she was the nurse to complete the fall investigation, LPN #8 stated that the nurse for Resident #218

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on that shift was not an employee of the facility, but was a temporary nurse from a nurse staffing agency. LPN #8 stated this nurse (LPN #9) was "still on a med (medication) cart when this happened." LPN #8 stated she assessed the resident for all the normal checks after a fall, including range of motion and neurological issues. LPN #8 stated she instructed LPN #9 to go in and check on Resident #218 once she finished her medication administration. LPN #8 stated: "I got [LPN #9]'s witness statement. I was never able to figure out why he fell." When the surveyor read LPN #9's witness statement to her, and asked why this incident, as reported by Resident #218, was not investigated as anything other than an unwitnessed fall, LPN #8 did not respond. When asked if she had read LPN #9's witness statement, LPN #8 stated: "The agency nurse went in and talked to [Resident #218]. He said he was pushed. But he was really manic. No one could substantiate what happened." When asked if anyone interviewed Resident #219 on 6/25/16, LPN #8 stated she tried to talk to him, "but he speaks only Spanish. That is a problem. He speaks only in Spanish. He just kept saying 'I don't love him.'" When asked what the facility staff members have been trained to do in response to the report of a resident to resident incident, LPN #8 stated the staff is supposed to separate the residents, ensure their safety, make sure they are not in the same room and report it to the DCS (director of clinical services). She stated she talked with both ASM #2 and ASM #3 within 15 minutes of the incident. LPN #8 stated: "ASM #2 told me to do an investigation." She continued: "They (Residents #218 and #219) self-separated. [Resident #219] stayed in his room the rest of the day." When asked how she knew this, she stated that she and the other staff

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"checked on him." LPN #8 went on to say that she worked double shifts (16 hour shifts) on both 6/25/16 and 6/26/16. When informed that other CNAs and nurses who worked that day and on 6/26/16 did not know anything about a need for Resident #219 to stay in his room due to safety concerns, LPN #8 did not respond. When asked if she updated the care plan for either resident, LPN #8 stated: "No, I did not. The floor nurse should do the update." LPN #8 stated that the night shift supervisor working from 6/25/16 to 6/26/16 was made aware of the incident. (This nurse was not available for interview during the survey).

On 6/29/16 at 1:50 p.m., LPN #4 was interviewed about the process to be followed after a resident to resident incident. She stated that both residents should be assessed and interviewed. She stated that all documentation should be up to date, and that the physician, social worker, supervisor and family should be notified immediately. She stated that the unit managers are responsible for updating care plans on weekdays, and that the weekend supervisors are responsible for updating care plans on the weekend. LPN #4 stated that the incident described in the 6/25/16 notes for Resident #218 and #219 should have been investigated and the care plan revised for both residents. LPN #4 stated that supervision should have been increased for both residents, especially since they are both independently ambulatory.

On 6/29/16 at 1:55 p.m., ASM #3, the director of clinical services, was interviewed about the events of 6/25/16. ASM #3 stated she was called "when it happened." She stated she came to the facility. ASM #3 stated: "You can't interview

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[Resident #219] because he is Hispanic. There were no injuries. I got witness statements from the staff." When asked from which staff she obtained witness statements, ASM #3 stated: "[LPN #9]." When asked if she obtained any other staff statements, ASM #3 said she did not. She stated: "I did an investigation and wrote it up." At this time, AM #3 provided the surveyor with a typed document dated 6/27/16 and titled "Investigation Synopsis." This document contained neither her name, nor her signature, nor any type of verifiable date stamp. Review of this document revealed, in part, the following: "Re: (regarding) possible resident to resident [Resident #218] and [Resident #219]. Methods of Investigation: Resident interview, Staff interview. Summary of findings:...On June 25, 2016 while in dining room when [Resident #218] came into [Resident #219]'s personal space causing [Resident #219] to become angry and pushing [Resident #218] to the floor. Both residents were separated immediately and assessed for injury. An interview was conducted by staff with [Resident #218] whom (sic) at the time was noted to be rambling with his words and noted to be in a heightened state or mania, however was able to state to staff that "The Hispanic man pushed me" during the interview. Resident was assessed no injuries were noted. [Resident #218] complained of back pain and was medicated with prn Tylenol. A physician's order for an x-ray of the cervical area of the back was obtained and the results were negative. [Resident #219] was interviewed by staff but was unable to give details of the incident but did state, "I told him I don't love him and I pushed him down." Both responsible parties and MD (medical doctor) were notified. In conclusion: After investigating the incident that occurred, a psychiatric consult was ordered for

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both residents because of each resident's altered mental status. Labs (laboratory tests) were also ordered for [Resident #218]. Care plans were also updated to reflect interventions and behaviors." When ASM #3 was asked, again, if the care plans were updated as stated in this document, she stated: "No." ASM #3 stated she told the nurses to place both residents on the list to be seen by the psychologist. When asked what interventions were put in place immediately to keep the residents safe from each other, ASM #3 did not answer. When asked what should have been done, ASM #3 stated: "They should have immediately been separated. They should be updating the care plans and giving reports to the CNAs so they can monitor them. We need to increase supervision in the dining room. Someone needs to walk them back and forth from the dining room to the units."

On 6/29/16 at 2:00 p.m., LPN #9 was interviewed by phone. She stated: "The supervisor told me I had to go and interview [Resident #218] after it happened." She stated Resident #218 had been "manic" all morning, as demonstrated by talking quickly and nonsensically. She stated Resident #218 told her that when he was standing up in the dining room, Resident #219 approached him and hit him "vehemently and suddenly." When asked for clarification of the adverbs "vehemently and suddenly," she stated these are her interpretations of what Resident #218 told her. She stated that Resident #218 was adamant that Resident #219's actions were quick and violent. She stated that she also attempted to speak with Resident #219. She stated he told her that Resident #218 was cursing at him, acting as though Resident #218 was going to punch him. She stated she reported the results of both these

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interviews to the supervisor (LPN #8), and that LPN #8 told her to write down her interview with Resident #218 on a fall report witness statement. She stated she was not asked to write down the results of her interview with Resident #219. When asked if, as an agency nurse, she had received any specific training on this facility's procedures to be followed in the case of a report of a resident to resident altercation. She stated she had not received any such education or in-service. She stated her first reaction would be to separate the residents. She stated she had instructed the CNAs working that shift to watch both residents and to "keep an eye on them." When told that none of the CNAs working that day remembered being told to do any sort of special monitoring, she did not respond. When asked if she updated the care plan for either resident, she stated, "No."

On 6/29/16 at 2:15 p.m., LPN #3, who was responsible for both Residents #218 and #219 that day, was interviewed. She stated she was not aware of any interventions put in place to keep these residents apart. She stated, "They both walk the halls all the time."

On 6/29/16 at 3:25 p.m., an attempt was made to interview Resident #219. LPN #3 accompanied this surveyor to Resident #219's room. Using limited Spanish, the surveyor was able to obtain consent from the resident to interview him about the events of 6/25/16. Using a smartphone application provided by LPN #3, the surveyor asked Resident #219 what happened on 6/25/16. Resident #219 stated repeatedly that Resident #218 called him "trash" and made him feel like "trash." When asked if he pushed Resident #218 to the ground, he shook his head negatively.

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When asked if he would ever push Resident #218 down in the future, he stated: "I do not love him. He said I am trash."

On 6/29/16 at 3:35 p.m., ASM #2, the regional director of clinical services, was interviewed regarding these events. She stated: "I called the facility on that Saturday like I always do on a weekend. I spoke to [LPN #8] and she said, 'We had an incident.'" She stated LPN #8 told her that Resident #218 has a history of manic phases and gets in other residents' personal space sometimes. She stated LPN #8 told her that [Resident #219] is being treated for dementia. She stated LPN #8 told her that [Resident #218] had told [LPN #8] that [Resident #219] had pushed him. She stated: "I told her to investigate. And I never got a call back. I did not follow up on Sunday. I did follow up on Monday after the morning meeting. None of the stories matched up." When asked if the allegations and the stories not matching up were not reasons for safety measures to be implemented immediately on 6/25/16 and continuing through the weekend and to the present time, ASM #2 did not respond right away. After a few seconds, she stated: "We have tried to do so much. We have come a long way, and this is a fluke. We have not had agency nurses in here since that day (6/25/16). This staff is sabotaging itself. It is so hard."

On 6/29/16 at 5:15 p.m., ASM #1, the executive director and administrator of record, ASM #2, ASM #3 and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns. Policies regarding safety interventions and resident to resident altercations were requested. These staff members were also invited to provide the survey

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team with any other evidence of investigation or implementation of safety measures for both residents.

A review of the policy entitled "Resident Abuse" revealed, in part, the following: "No employee may at any time commit an act of physical, psychological or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident...Physical abuse...striking the resident with a part of the body or with an object; nontherapeutic shoving, pushing pulling, or twisting any part of the resident's body...Physical contact intentionally or through carelessness that results in or is likely to result in death, physical injury, pain or psychological harm to the resident...acts of abuse directed against residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible criminal prosecution." On 6/30/16 at 8:30 a.m., ASM #3 and RN #1 were asked if this policy referred to resident to resident altercations and to resident safety after an altercation. ASM #3 stated, "You have everything we have."

A review of the policy entitled "Behavior Monitoring" failed to reveal information related to resident to resident altercations and the provision of a safe environment after such events.

No further information was provided prior to exit.

(1) "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality and mood problems (depression or mania)." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

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(2) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

Complaint Deficiency

2. The facility staff failed to develop and implement interventions to keep Resident #205 safe following the 6/22/16 altercation with another resident.

Resident #205 was admitted to the facility on 9/22/09 with diagnoses that included but were not limited to: legally blind, anxiety, depression, osteoarthritis, high blood pressure and arthritis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/27/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing supervision for activities of daily living. The resident was coded as not having behaviors directed towards others.

Resident #221 was admitted to the facility on 7/24/13 and readmitted on 5/7/15 with diagnoses that included but were not limited to: liver failure, high blood pressure, personality disorder, dementia and depression.

The most recent MDS, a quarterly assessment, with an ARD of 5/3/16 coded the resident as having a two of 15 on the BIMS indicating the

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resident was severely impaired cognitively to make daily decisions. The resident was coded as having behaviors but not directed towards others.

Review of Resident #205's nurse's note dated 6/22/16 at 11:15 a.m. documented, "Resident noted being involved with another resident in an (sic) physical altercation, this resident states he was rolling to the dining room for lunch when another resident was coming from out of dining room, their wheelchairs collided then the other resident hit this resident in the arms residents were immediately removed from each other the resident that was hitting was taken back to room, residents bilateral arms assessed (no) bruising noted @ this time (no) c/o (complaints of pain) (no) s+s (signs and symptoms) discomfort noted while talking (with) resident resident also states the other resident did not hit him hard he is fine was just startled RP (responsible party) + MD (medical doctor) aware."

Review of the resident's care plan dated 6/22/16 documented, "PROBLEM 6/22/2016. propels w/c (wheelchair) (without) assistance risk to run into others. GOAL 6/22/2016 Resident will not roll into others while in w/c." Further review of the care plan did not evidence documentation of an approach or intervention to keep the resident safe from others.

On 6/29/16 at 8:50 a.m. an interview was conducted with RN (registered nurse) #2, the unit manager. When asked about the 6/22/16 altercation, RN #2 stated, "I didn't see it, but the other resident came out of the dining room and bumped into him (Resident #205)." When asked how this information was documented or shared with staff, RN #2 stated, "I know we gave a verbal

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report." When asked what the intervention was for the 6/22/16 altercation, RN #2 stated, "I see we've got to see how to keep him safe."

On 6/29/16 at 4:05 p.m. an interview was conducted with ASM (administrative staff member) #3, the director of clinical services. When asked the process staff followed in documenting a resident to resident altercation, ASM #3 stated, "We should be updating the care plan, put it on the 24 hour report. Nurses should be giving report to the CNAs (certified nursing assistants) so they know what to monitor." When asked to review Resident #205's care plan for interventions to keep Resident #205 safe from others, ASM #3 stated, "There's no documentation. I don't see anything."

On 6/29/16 at 5:30 p.m. ASM #1, the administrator, ASM #2, the regional director of clinical services and ASM #3, the director of nursing were made aware of the findings.

Review of the facility's policy titled "Resident Abuse" documented in part, "Policy: It is inherent in the nature and dignity of each resident at The company that he/she be afforded basic human rights, including the right to be free from abuse, neglect.....Prevention. Monitoring of residents who may be at risk is the responsibility of all facility staff. this included monitoring resident (sic) who are at risk or vulnerable for abuse for indications of changes in behavior...."

No further information was provided prior to exit.

{F 328} 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS {F 328}
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{F 328}	Continued From page 70 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen per physician's order for two of 21 residents in the survey sample, Residents # 203 and # 206. 1. The facility staff failed to administer oxygen at the physician's prescribed flow rate of two liters per minute for Resident # 203. 2. For Resident #206 facility staff failed to administer the oxygen at 80% humidity and 2.5 liters/minute as ordered by the physician. The findings include: 1. Resident # 203 was admitted to the facility on 10/26/12 and most recently readmitted on 2/23/13 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, convulsions, depression, peripheral vascular disease, coronary artery disease, hypertension,	{F 328}	RECEIVED JUL 15 2016 VDH/OLC 7/27/2016 1. Residents #203 and #206 are receiving oxygen as per MD order.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 328}	Continued From page 71 hyperlipidemia, atrial fibrillation, abdominal aortic aneurysm, glaucoma, diabetes, and kidney disease. Resident # 203's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/3/16, coded Resident # 203 as usually understood by others and usually understanding others. Resident # 203 was coded as scoring 10 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired. Section O documented the resident received oxygen therapy during the last 14 days. Review of Resident # 203's clinical record revealed physician orders with a start date of 4/15/13 that were most recently signed by the physician on 6/10/16. The physician order documented: "O2 @ 2L (oxygen at 2 liters per minute) VIA NASAL CANNULA CONTINUOUS HUMIDIFIED FOR SHORTNESS OF BREATH." Resident # 203's comprehensive care plan initiated on 4/1/14 and revised 9/15/14 documented, under "PROBLEM" "Focus Category: Cardiovascular" Under "APPROACHES & INTERVENTIONS...Administer oxygen as ordered." "IMP (implementation) DATE 4/13/16." Another care plan initiated 4/1/14 and revised 9/15/14 documented: under "PROBLEM" "Focus Category: Respiratory" Under "APPROACHES & INTERVENTIONS...Oxygen as ordered (specify route, device, and liter flow) O2 (oxygen) via N/C (nasal cannula) @ 2LPM (liters per minute)." "IMP (implementation) DATE 4/13/16."	{F 328}	2. Residents with orders for oxygen have the potential to be affected. Resident records were reviewed to ensure orders are being followed and settings are accurate. 3. In-servicing has been provided to nursing staff by the DCS/designee on administering oxygen as ordered to include humidification settings. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure oxygen and humidification settings are as per MD orders. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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Resident # 203 was observed on 6/28/16 at approximately 11:45 a.m. and again on 6/28/16 at 3:55 p.m. During each of these observations Resident # 203 was receiving oxygen via a nasal cannula and the oxygen concentrator was set at 1 and 3/4 liters per minute as evidenced by the bottom of the ball in the concentrator flow meter resting on the 1 ½ liter mark and the top just touching the 2 liter mark.

During an interview and observation of Resident # 203's oxygen on 6/28/16 at 4:20 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 confirmed the oxygen flow meter had the bottom of the ball resting on the 1.5 liter mark. LPN # 2 stated that she would have to check the physician's order. LPN # 2 returned stating that the order was for 2LPM.

During an interview on 6/28/16 at 4:35 p.m. with ASM (administrative staff member) # 1, the administrator and ASM # 2, the corporate nurse, the finding of the incorrectly set oxygen was revealed. At this time a request was made for the facility policy.

Review of the facility policy "Oxygen Therapy" Under "PROCEDURE: 1. Review physician's order...9. Start O2 flowrate at the prescribed liter flow..."

Review of the manufacturer's User Manual revealed the following: Page 19. "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

No further information was presented prior to exit.

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According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

2. Resident # 206 was admitted to the facility on 7/29/15 and most recently readmitted on 5/16/16 with diagnoses that included but were not limited to: chronic respiratory failure, convulsions, quadriplegia, Down Syndrome, dementia, gastro-esophageal reflux disease, neurogenic bladder, and hypertension.

Resident # 206's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/16, coded Resident # 206 as never/rarely understood by others and never/rarely understanding others. Resident # 206 was coded as severely impaired for Cognitive Skills for Daily Decision Making in Section C, Cognitive Patterns.

Review of Resident # 206's clinical record revealed a telephone order dated and signed on 6/3/16 by the physician that documented: "O2 @ 2.5 ml/min. Via Trach to equal 30% oxygen, 20 PSI, 80 % humidifier Q shift." This order again appeared on the Physician Order Sheet and was signed by the physician on 6/6/16. NOTE: O2 =

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oxygen; @ = at; ml = milliliters; min = minute; trach = tracheostomy (tube in an opening in windpipe to support breathing); PSI = pounds per square inch (pressure at which oxygen is delivered); Q = every.

Resident # 206's comprehensive care plan initiated on 4/1/14 and revised 9/15/14 documented, under "PROBLEM" "Focus Category: Cardiovascular" dated 8/11/15. Under: "APPROACHES & INTERVENTIONS...Administer oxygen as ordered."

Observations of Resident # 206's oxygen equipment were made on the following dates and times:

- 6/28/16 at on initial tour at approximately 11:30 a.m. O2 flow meter was set to 3L/min. (ball centered on 3L line)
- 6/28/16 at 3:50 p.m. O2 flowmeter was set to 3 L/min. (ball centered on 3L line)
- 6/29/16 at 8:00 a.m. O2 flowmeter was set to 2 ¼ L/min (bottom of ball sitting on 2L line with top of ball at the 2.5 L line)
- 6/29/16 at 9:29 a.m. O2 flow meter was set to 2 ¾ L/min. (bottom of ball sitting on 2.5 L line with top of ball on the 3 L line)
- 6/29/16 at 10:10 a.m. O2 flow meter was set to 2.5 L/min and Humidity was set to 28% (instead of the ordered 80 %)
- 6/29/16 at 12:58 p.m. O2 flowmeter was set to 2.5 L/min and Humidity was set to 28% (instead of the ordered 80 %) [This was also observed by LPN (licensed practical nurse) # 3 on 6/29/16 at 12:58p.m.]
- 6/29/16 at 1:05 p.m. O2 flow meter was set to 2.5 L/min and Humidity was set to 28 % (instead

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of the ordered 80 %) [This was also observed by LPN # 4, the unit manager on 6/29/16 at 1:05 p.m.]

Review of the manufacturer's User Manual revealed the following: Page 19. "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

During an interview on 6/29/16 at 12:58 p.m. with LPN # 3 Resident # 206's oxygen equipment was observed. The O2 flow meter read 2.5 L/min (as ordered) and the humidity read 28 % (80% being the ordered amount). LPN # 3 agreed with the reading and went to check the physician order.

During an interview on 6/29/16 at 1:05 p.m. with LPN # 4, LPN # 4 came into the room and adjusted the humidity setting to 80%. When asked what the reading was before she (LPN # 4) adjusted the setting she stated that it was set to 28%.

During an interview on 6/29/16 at 1:07 p.m. with LPN # 3, LPN # 3 stated that she had not adjusted any of the settings on Resident # 206's oxygen equipment.

During an interview on 6/29/16 at 1:20 p.m. these observations were shared with ASM (administrative staff member) # 2, the corporate nurse, and a request was made for any policy or information on Resident # 206's oxygen equipment.

During an interview on 6/29/16 at 2:50 p.m. with

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LPN # 4, LPN # 4 suggested that perhaps the Resident's brother had adjusted the O2 settings. At this time a request was made for any documentation to corroborate that assertion; nurse's notes, care plan, education of family. Prior to exit no documentation was provided. At this time LPN # 4 was asked explain how one would read the oxygen flow meter. LPN # 4 stated that one would get down to eye level and that the ball should be centered on the line of the prescribed flow rate.

During an interview on 6/29/16 at 3:50 p.m. with Resident # 206's brother, the brother was asked, "Have you ever touched your brother's (Resident # 206) oxygen equipment." The brother answered, "No, I do not."

During an interview on 6/29/16 at 4:00 p.m. with LPN # 3, LPN # 3 stated, "I knew it was supposed to be on 80 %, I saw that it was on 28 % I went out to read the chart and the (name of LPN # 4) came in and she fixed it. I do not know how it got to be set on 28 %. I have been going in more frequently since then to check and it has been correct each time."

Review of the facility policy "Oxygen Therapy" Under "PROCEDURE: 1. Review physician's order...7. Attach humidifier or nebulizer to flowmeter, if indicated. 8. Attach administration device to flowmeter or humidifier/nebulizer outlet. 9. Start O2 flowrate at the prescribed liter flow..."

Review was made of the educational information provided by ASM # 2 entitled "High Humidity Set-Ups Utilizing Liquid Oxygen and /or Concentrator with Air Compressor." ASM # 2

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stated that this was the educational information provided to nurses. The educational information was a one page diagram and in the bottom right hand corner was an inset showing how to adjust the humidification. "Match pointer with notch on Jet Nebulizer Dial at 80%."

No further information was presented prior to exit.

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F 329 SS=D — 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS — F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition

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as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure the drug regimen for two of 21 residents in the survey sample, (Resident #212 and Resident #214) was free from unnecessary medications.

1. Facility staff failed to identify, monitor and document behaviors indicating the need for Resident #212's Risperidone (an atypical antipsychotic medication (1)).

2. Facility staff failed to identify, monitor and document behaviors indicating the need for Resident #214's Risperidone.

The findings include:

1. Resident #212 was admitted to the facility on 4/26/16 with diagnoses that included but were not limited to: dementia, anxiety, psychosis and bipolar disease (2).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/24/16 coded the resident as

7/27/2016

1. Resident #212 and #214 have behavior monitoring sheets with targeted behaviors.
2. Residents in the facility have the potential to be affected. Resident receiving psychoactive medications were reviewed to ensure that behavior monitoring forms were present.

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having a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively to make daily decisions. In section E titled, Behavior, the resident was coded as wandering for one to three days in the look back period. The resident was coded as requiring supervision to assistance of one staff member for activities of daily living.

Review of Resident #212's care plan implemented on 5/9/16 documented, "Focus: Antipsychotic medication. APPROACHES & INTERVENTIONS. Monitor behavioral symptoms...."

Review of the physician's orders dated, 6/30/16 documented, "RISPERIDONE F/C 0.5MG (milligrams) TABLET. TAKE 1 TAB (tablet) BY MOUTH EVERY MORNING. RISPERIDONE F/C/ 0.5MG TAKE 2 TABLETS (1mg) BY MOUTH AT BEDTIME FOR PSYCHOSIS."

Review of the June 2016 MAR (medication administration record) documented, "RISPERIDONE F/C 0.5MG TABLET TAKE 1 TAB BY MOUTH EVERY MORNING. RISPERIDONE F/C/ 0.5MG TABLET TAKE 2 TABLETS (1MG) BY MOUTH AT BEDTIME FOR PSYCHOSIS." It was documented that the medication had been administered as ordered each day during June 2016.

Review of Resident #212's behavior monitoring flow record did not evidence documentation of identified targeted behaviors for receiving the Risperidone, and there was no documentation for monitoring of behaviors.

Review of the nurse's notes from 6/22/16 to

3. Nursing staff will be in-serviced on the behavioral policy as it relates to monitoring behaviors and documentation of targeted behaviors. DCS/designee will audit 5 residents receiving antipsychotic medications weekly X 3 months to ensure that targeted behaviors are being monitored and documented on the behavior flow sheet.
4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.

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6/30/16 did not evidence documentation related to behaviors that would indicate the resident did or did not require the Risperidone.

On 6/29/16 at 10:52 a.m. an interview was conducted with LPN (licensed practical nurse) #4, regarding what staff monitor for when a resident was on antipsychotic medications. LPN #4 stated, "See if they have allergic reaction to it, monitor for falls, change in mental status, and see if it's taking effect." When asked how staff would know if the medication was effective, LPN #4 stated that the behaviors the resident exhibited that led them to be on the antipsychotic medication would have lessened. When asked where this would be documented, LPN #4 stated, "If I observe he has that type of behavior, yes." When asked how staff knew what targeted behaviors were to be monitored in relation to the Risperidone for Resident #212, LPN #4 stated, "It would be on the chart." LPN #4 was asked to check the Risperidone order for Resident #212. LPN #4 stated, "It says psychosis." When asked if psychosis was a behavior, LPN #4 stated, "No."

On 6/29/16 at 11:10 a.m. an interview was conducted with LPN #1, a unit manager, regarding the process staff followed when a resident was on an antipsychotic medication. LPN #1 stated, "Basically we get an order from the psychiatrist's documentation, we see a diagnosis. We monitor behaviors." When asked where these behaviors were documented, LPN #1 stated, "We place it on the (24) hour report for a week." When asked if residents on antipsychotics had targeted behaviors for monitoring, LPN #1 stated, "Some do. It could be a starting point but they could exhibit other behaviors than that and we would monitor for it.

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We would care plan it."

On 6/29/16 at 3:35 p.m. an interview was conducted with LPN #10, regarding what staff monitored when a resident was on antipsychotic medications. LPN #10 stated, "We document their behaviors." When asked where this would be documented, LPN #10 stated that it would be in the nurse's notes, on the behavior sheets and on the 24 hour report. When asked how staff would know the targeted behaviors the resident was being monitored for, LPN #10 stated, "It would be documented in the chart."

On 6/30/16 at 8:10 a.m. an interview was conducted with ASM (administrative staff member) #2, the regional director of clinical services. When asked where staff documented targeted behaviors for residents on antipsychotic medication, ASM #2 stated, "Our policy is when a behavior occurs we write (about) that behavior for 24 hours. We document it, notify the doctor and monitor it for 24 hours." When asked how staff knew the targeted behaviors they were to monitor, ASM #2 stated, "The behavior sheets shouldn't be put on the chart unless they are having behaviors. We probably should document, everyday, we used to, but we don't anymore since the policy changed." ASM #2 was made aware of the findings at that time.

Review of the facility's policy titled "Psychoactive Medications" documented in part, "Policy:....and the right to be free of unnecessary medications. Procedure: 3. c. Residents with behaviors will be monitored using a behavior symptom flow record when behaviors are present."

No further information was provided prior to exit.

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(1) Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as risperidone have an increased risk of death during treatment. Older adults with dementia may also have a greater chance of having a stroke or mini-stroke during treatment.
(2) Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.
http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

2. Resident #214 was admitted to the facility on 3/31/08 with diagnoses that included but were not limited to: Alzheimer's disease, high blood pressure, dementia and anxiety.

The most recent MDS, a quarterly assessment, with an ARD of 5/13/16 coded the resident as having rarely makes self understood and rarely able to understand others. In section E, titled Behavior, the resident was coded as wandering on a daily basis. The resident was coded as requiring supervisor to one person assist for activities of daily living.

Review of Resident #214's care plan titled, "Behavior/Mood" documented in part, "Focus:

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Impaired or inappropriate behaviors. As Evidenced By: Wandering. 5/23/16 aggression towards other residents. APPROACHES AND INTERVENTIONS. Monitor behavioral symptoms...."

Review of the physician's orders dated and signed on 6/6/16 documented, "Risperdal (risperidone) 0.5mg by mouth twice daily. INDICATION - DX (diagnosis) Psychosis."

Review of the June MAR documented, "Risperdal 0.5 mg by mouth BID (twice a day). psychosis." It was documented that the resident received the medication twice a day starting on 6/7/16 as ordered.

Review of the June 2016 behavior monitoring flow record did not evidence documentation of targeted behaviors or the use of the Risperdal or any documentation that the behaviors had been monitored.

Review of the nurse's notes did not evidence documentation from 6/22/16 to 6/30/16.

On 6/29/16 at 10:52 a.m. an interview was conducted with LPN (licensed practical nurse) #4, regarding what staff monitor for when a resident was on antipsychotic medications. LPN #4 stated, "See if they have allergic reaction to it, monitor for falls, change in mental status, and see if it's taking effect." When asked how staff would know if the medication was effective, LPN #4 stated that the behaviors the resident exhibited that led them to be on the antipsychotic medication would have lessened. When asked where this would be documented, LPN #4 stated, "If I observe he has that type of behavior, yes."

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NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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When asked how staff knew what targeted behaviors were to be monitored in relation to the Risperdal, LPN #4, "It would be on the chart." LPN #4 was asked to check the Risperdal order for Resident #214. LPN #4 stated, "It says psychosis." When asked if psychosis was a behavior, LPN #4 stated, "No."

On 6/29/16 at 11:10 a.m. an interview was conducted with LPN #1, a unit manager, regarding the process staff followed when a resident was on an antipsychotic medication. LPN #1 stated, "Basically we get an order from the psychiatrist's documentation, we see a diagnosis. We monitor behaviors." When asked where these behaviors were documented, LPN #1 stated, "We place it on the (24) hour report for a week." When asked if residents on antipsychotics had targeted behaviors for using the medication, LPN #1 stated, "Some do. It could be a starting point but they could exhibit other behaviors than that and we would monitor for it. We would care plan it."

On 6/29/16 at 3:35 p.m. an interview was conducted with LPN #10, regarding what staff monitored when a resident was on antipsychotic medications. LPN #10 stated, "We document their behaviors." When asked where this would be documented, LPN #10 stated that it would be in the nurse's notes, on the behavior sheets and on the 24 hour report. When asked how staff would know the targeted behaviors the resident was being monitored for, LPN #10 stated, "It would be documented in the chart."

On 6/30/16 at 8:10 a.m. an interview was conducted with ASM (administrative staff member) #2, the regional director of clinical

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services. When asked where staff documented targeted behaviors for residents on antipsychotic medication, ASM #2 stated, "Our policy is when a behavior occurs we write (about) that behavior for 24 hours. We document it, notify the doctor and monitor it for 24 hours." When asked how staff knew the targeted behaviors they were to monitor for, ASM #2 stated, "The behavior sheets shouldn't be put on the chart unless they are having behaviors. We probably should document, everyday, we used to, but we don't anymore since the policy changed." ASM #2 was made aware of the findings at that time.

Review of the facility's policy titled "Psychoactive Medications" documented in part, "Policy:....and the right to be free of unnecessary medications. Procedure: 3. c. Residents with behaviors will be monitored using a behavior symptom flow record when behaviors are present."

No further information was provided prior to exit.

{F 514} SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (F 514}

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for two of 21 residents in the survey sample, Resident #204 and Resident #221.

1. The facility staff failed to document the physician ordered oxygen on the MAR (medication administration record) for Resident #204.

2. The facility staff updated Resident #221's care plan on 6/22/16 with the intervention for a psychiatry consult. The psychiatry consult was not ordered until 6/29/16.

The findings include:

1. Resident #204 was admitted to the facility on 6/7/16 with diagnoses that included but were not limited to: chronic lung disease, congestive heart failure, kidney disease and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 6/14/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. In section O titled "Special Treatment, Procedures, and Programs" the resident was coded as receiving oxygen therapy.

Review of Resident #204's care plan implemented on 6/20/16 documented, "Focus

7/27/2016

1. Resident #204 is receiving oxygen as ordered and it is documented on the MAR. Resident #221 was seen by Psychiatric services on 6/30/16.
2. Residents that reside in the facility have the potential to be affected. A review of oxygen orders was conducted and all orders are current and oxygen therapy implemented as ordered. Oxygen orders are signed off in MAR. Residents with orders for Psychiatric services are being provided services as ordered.

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{F 514}	Continued From page 87 Category: Cardiovascular. APPROACHES & INTERVENTIONS. Administer oxygen as ordered." There was not documentation regarding documenting the oxygen. Review of the physician's orders dated 6/9/16 and signed on 6/28/16 at 3:00 p.m. documented, "Oxygen @6L/M (liters/minute) via NC (nasal cannula - soft prongs that fit in the nose to deliver oxygen) continuous." Review of the June 2016 MAR (medication administration record) documented, "Oxygen @ 6 L/M via NC continuous 6/28/16." There was no documentation that the oxygen was administered. On 6/30/16 at 9:25 a.m. an interview was conducted with LPN (licensed practical nurse) #11. When asked why the MAR (medication administration record) was signed off by staff every day, LPN #11 stated, "To show we gave the med (medication) as ordered. When asked if oxygen was considered a medication, LPN #11 stated, "Yes." When asked if it was also documented on the MAR, LPN #11 stated, "I'm not sure about that one, I want to say yes. If it's on continuous it's documented somewhere." When asked if she would sign off the oxygen if it was documented on the MAR, LPN #11 stated, "Yes I would." LPN #11 reviewed the resident 204's MAR for June 2016 and stated the oxygen had not been signed off. On 6/30/16 at 10:00 a.m. ASM #2, the regional director of clinical services, was made aware of the findings. A request for the facility's oxygen policy was requested but not received. No further information was provided prior to exit.	{F 514}	3. Licensed nurses will be educated on accurate and complete documentation of medications and treatments on the MAR to include oxygen therapy. B) in-services will also include documentation of Physician refusal for recommended services by nursing. Random weekly audits will be conducted to ensure nursing signatures are present on MAR records to indicate administration of medications to include oxygen X 3months. 4. Results will be reviewed and discussed during the QAPI meeting monthly x 3 months for recommendations.	

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According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

2. Resident #221 was admitted to the facility on 7/24/13 and readmitted on 5/7/15 with diagnoses that included but were not limited to: liver failure, high blood pressure, personality disorder, dementia and depression.

The most recent MDS, a quarterly assessment, with an ARD of 5/3/16 coded the resident as having scored a two of 15 on the BIMS indicating the resident was severely impaired cognitively to make daily decisions. The resident was coded as having behaviors but not directed towards others.

Review of Resident #221's care plan for behavior documented, "6/22/16 Psych (psychiatry) consult."

Review of the nurse's notes dated 6/22/16 at 11:00 a.m. documented, "Resident was in an altercation with another resident in which he hit the other resident several times. Residents were immediately separated (sic) time. MD (medical doctor) called and notified...No new orders given."

Review of the physician's orders from 6/22/16

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through 6/28/16 did not evidence an order for the psychiatry consult.

Review of the physician's orders dated 6/29/16 documented, "psych (psychiatry) consult".

On 6/29/16 at 3:30 p.m. an interview was conducted with LPN (licensed practical nurse) #10. When asked who updated the care plans, LPN #10 stated, The MDS coordinator prefers to write on them but we let them know (of any changes) and the unit manager takes it to the morning meeting so they can update it."

On 6/30/16 at 8:10 a.m. an interview was conducted with ASM (administrative staff member) #2, the regional director of clinical operations. ASM #2 stated, "I talked to the nurse (who cared for Resident #221 on 6/22/16) and she said she called (name of doctor) and he didn't want it (the psychiatric consult). I asked her why she didn't document it." ASM #2 was made aware of the findings at that time.

On 6/30/16 at 9:20 a.m. an interview was conducted with LPN #1, the nurse who cared for Resident #221 on 6/22/16, LPN #11 stated, "The doctor told me, uh huh, okay and hung up. He didn't give me any new orders." When asked who had updated the resident's care plan, LPN #11 stated, "I don't know who did that." When asked who updates care plan, LPN #11 stated, "I have not updated the care plans, it's been the unit manager's who've updated them." When asked who used the care plans, LPN #11 stated, "The nursing staff, the charge nurses, the unit manager and MDS (coordinators)." When asked why the care plan was updated, LPN #11 stated, "So we're all on the same page and aware of

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what's going on." When asked if it was important for the care plan to be accurate, LPN #11 stated, "I think it's very important. It should be accurate so everyone's on the same page to get to the same goal."

Review of the facility's policy titled, "Plans of Care" documented, Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary."

Review of the facility's policy titled, "Clinical/Medical Records" documented in part, "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The clinical record shall contain -- information to identify the resident clearly...the plan of care....The purpose of the clinical record is to document the course of the residents plan of care and to provide a medium of communication among health care professionals involved in this care."

No further information was provided prior to exit.